

DRAFT RULES AND REGULATIONS
FOR HOSPICE IN ARKANSAS

ARKANSAS DEPARTMENT OF HEALTH ~~1983~~2005
(~~Pursuant to Act 283 of 1983~~)

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SECTION 1: PREFACE

These rules and regulations have been prepared for the purpose of establishing ~~a criterion~~ for minimum standards for the ~~licensure certification~~, operation and maintenance of hospices in Arkansas that is consistent with current trends in patient care practices. By necessity they are of a regulatory nature but are considered to be practical minimal design and operational standards for these facilities. These standards are not static and are subject to periodic revisions in the future as new knowledge and changes in patient care trends become apparent. However, it is expected that facilities will exceed these minimum requirements and that they will not be dependent upon future revisions in these standards as a necessary prerequisite for improved services. Hospices have a strong moral responsibility for providing optimum patient care and treatment for the terminally ill and their families.

SECTION 2: AUTHORITY

The following Rules and Regulations for Hospices in Arkansas are duly adopted and promulgated by the Arkansas State Board of Health pursuant to the authority expressly conferred by the laws of the State of Arkansas in ~~Act 283 of 1983~~ Ark. Code Ann. § 20-7-117 and § 20-7-123.

SECTION 3: PURPOSE

To establish rules, regulations and minimum standards for hospice programs operating in the State of Arkansas in accordance with ~~Act 283 of 1983~~ [Ark. Code Ann. § 20-7-117](#). These rules will ensure high quality professional care for terminally ill patients and their families by providing for the safe, humane and appropriate palliative care of all admitted to a hospice program regardless of setting and shall apply to both new and existing agencies.

SECTION 4: DEFINITIONS

The word **shall** as used in these regulations means mandatory.

- ~~5~~A. Administrator means the person responsible for the management of a hospice.
- ~~9~~B. Attending physician means a ~~physician who (a) is a~~ doctor of medicine or osteopathy who is licensed in the state of Arkansas; and ~~(b)~~ is identified by the ~~individual~~patient, at the time he/she elects to receive hospice care, as having the most significant role in the determination and delivery of the ~~individual~~patient's medical care.
- ~~8~~C. Autonomous means a separate and distinct entity which functions under its own administrations and bylaws either within or independently of a parent organization.
- ~~10~~D. Bereavement counseling means counseling services provided to the ~~individual's~~patient's family after the ~~individual's~~patient's death.
- E. Clergy means an individual with training in spiritual counseling.
- ~~2~~F. Department means the ~~State Board of Health~~Arkansas Department of Health.
- ~~17~~G. ~~Consent form~~Election Statement means ~~that~~the initial election for hospice care ~~must be informed consent~~ signed by the patient or patient's representative and ~~must~~shall be maintained in the ~~hospice~~patient's medical record.
- ~~11~~H. Employee means an ~~employee~~individual ~~of the hospice or, if the hospice is a subdivision of an agency or an organization, an employee of the agency or organization who is assigned and works substantially full-time for the hospice unit paid either through a salary or on an hourly or per visit basis and a W2 is issued on his/her behalf.~~ An "E~~e~~mployee" also refers to a volunteer under the jurisdiction of the hospice.
- I. Health Facility Services is the facility licensing division of the Department.
- ~~13~~J. Hospice Agency means ~~a public~~ any agency ~~or private organization or subdivision of either of these that is primarily engaged in providing care to terminally ill individuals,~~ person, partnership, association, corporation, or other organization whether public or private, proprietary, or non-profit, that provides hospice service.
- ~~6~~K. Hospice or hospice care means an autonomous, centrally administered, medically directed, coordinated program providing a continuum of home, outpatient, and home-like inpatient care for the terminally ill patient and family, employing an interdisciplinary team to assist in providing palliative and supportive care to meet the special needs arising out of the physical, emotional, spiritual, social and economic

stresses which are experienced during the final stages of illness and during dying and bereavement, with such care being available ~~twenty-four (24)~~ hours a day, ~~seven (7)~~ days a week and provided on the basis of need regardless of ability to pay-

L. Informed Consent specifies the type of care and services agreed upon by the hospice patient or the patient's representative.

M. In-patient Direct Care Hospice means a licensed hospice facility that provides direct in-patient care to the terminally ill.

N. **Functional** Program describes those services to be provided by the Hospice for the operation of the facility.

O. Registered Nurse (RN) means a person licensed in the State of Arkansas as a registered nurse.

16P. Representative means a person who is, because of the ~~individual's~~patient's mental or physical incapacity, authorized in accordance ~~the~~with State law to execute or revoke an election for hospice care or terminate medical care on behalf of the terminally ill ~~individual~~patient.

14Q. Social Worker means a person who has at least a Bachelor's Degree from a school accredited or approved by the Council on Social Work Education and is licensed by the State of Arkansas as a Social Worker.

15R. Terminally ill means that the ~~individual has a medical prognosis that his/her life expectancy is six (6) months or less~~ patient is in the last phases of an incurable illness and has a limited prognosis.

~~1. State Health Officer means the secretary for the State Board of Health.~~

~~3. Director means the chief administrative office in the Division of Health Facility Services.~~

~~4. Division means the Division of Health Facility Services.~~

~~7. Unit of care means the patient and those closely linked with the patient who may or may not be involved in the health and supportive care of a terminally ill patient.~~

~~12. Free standing hospice means a hospice that is not part of any other type of participating provider.~~

SECTION 5: INSPECTION REQUIREMENTS AND CODES

All agencies providing hospice services in the home shall comply with Sections 1 thru 21. In-Patient Direct Care Hospices shall comply with Sections 1 thru 36.

Any authorized representative of the department shall have the right to enter a hospice at any time in order to make whatever inspection is deemed necessary in accordance with the minimum standards and regulations prescribed herein (Moved to new Section 5.G.)

A. REQUIREMENTS FOR CERTIFICATIONLicensure

- A1. No public or private agency or person shall establish, conduct, or maintain a hospice or hold itself out to the public as a hospice without first obtaining certificationlicensure, ~~or provisional certification~~ from the department. ~~Hospice organizations that were in operation prior to enactment of Act 283 of 1983 shall make application to the department within sixty (60) days after these regulations are approved and filed.~~
- B2. CertificationLicensure to operate a hospice issued by the ~~d~~Department ~~will~~shall be based upon the results of an operational and physical plant survey conducted by the department to determine compliance with the Rules and Regulationss of Hospice. CertificationLicensure for the operation of a hospice program shall, unless sooner revoked, be for a period of one ~~(1)~~ year.
- ~~3. Temporary State Certification: Temporary state certification for one (1) year or less may be granted to a hospice provider, at the discretion of the Director of Health Facility Services, provided the following minimum standards are met:~~
- ~~a. Hospice care must be available twenty-four (24) hours a day, seven (7) days a week.~~
 - ~~b. There must be a Medical Director (Physician) and a full time Registered Professional Nurse.~~
 - ~~c. Palliative care must be provided.~~
 - ~~d. Care must be available both in the home and in an inpatient setting.~~
 - ~~e. Complete medical records must be maintained.~~
 - ~~f. The patient and family are considered the unit of care.~~
 - ~~g. Bereavement services are available.~~

~~h. Counseling is provided.~~

~~i. Volunteers are trained and utilized by the hospice.~~

~~j. There is an active plan developed to bring the hospice into compliance with state standards.~~

~~Temporary state certification may be revoked if appropriate progress is not made at any time as determined by the Director.~~

B. ~~Revocation~~ OF STATE CERTIFICATION OF HOSPICE CARE

The department ~~may~~ is empowered to deny, suspend or revoke ~~certification a license~~ on any of the following grounds:

1. Violation of any of the rules and regulations promulgated as developed under the authority of ~~Act 283 of 1983~~ Ark. Code Ann. § 20-7-117.
2. Permitting, aiding or abetting the commission of any unlawful act in connection with the operation of a hospice.
- ~~3.~~ Revocation shall be effective for a minimum of 90 days before the Department accepts reapplication.
- ~~4.~~ Right of Appeal shall be through the Arkansas Board of Health.

C. ~~Application~~ FOR STATE CERTIFICATION

An applicant shall file applications under oath with the ~~d~~Department upon forms prescribed by the ~~d~~Department. The application shall be signed by the owner; ~~if an individual or partnership, or in the case of a corporation, by two (2) of its officers; or in the case of a governmental unit by the head of the governmental unit having jurisdiction over it.~~

The application shall set forth the full name and address of the hospice for which state ~~certification~~ licensure is sought and such additional information as the department may require.

~~A certificate of need from the appropriate agency shall be submitted with the application papers.~~

An agency making initial application or requesting a change in service area shall submit a Permit of Approval (POA) from the appropriate agency.

D. ~~Change of Ownership~~

~~If change of ownership is contemplated, the new owner shall submit, or cause to be submitted, an application for and receive certification to continue operation of the hospice.~~

1. The hospice shall notify Health Facility Services in writing at least 30 days prior to the effective date of change of ownership.

2. The following information shall be submitted:

a) License application;

b) Request for Medicare Certification (where applicable);

c) Legal documents, ownership agreements, the license previously issued to the hospice, and other information to support re-license requirements; and

d) Licensure fee.

E. Name/Address Change

1. The hospice shall notify Health Facility Services in writing of any name and/or address change.

2. The following information shall be submitted:

a) The new address.

b) The previously issued license shall be returned to Health Facility Services.

c). Appropriate fee.

F. Management Contract

The licensed hospice shall notify Health Facility Services in writing at least 30 days prior to entering into a contract for overall management of the hospice. A copy of the contract shall be submitted to Health Facility Services.

G. Inspections

Any authorized representative of the department shall have the right to enter a hospice at any time in order to make whatever inspection is deemed necessary in accordance with the minimum standards and regulations prescribed herein.

SECTION 6: GOVERNING BODY

~~There shall be a governing body established by written bylaws of the hospice with autonomous authority for conduct of the hospice program and which shall satisfy the following:~~

~~1. Members shall reside or work in the geographical area or areas in which the hospice is certified to operate.~~

2. There must be a schedule of not less than quarterly meetings during each calendar year. (Moved to Section 6.E)

A. ~~A~~The hospice ~~must~~shall have a Governing Body that assumes full legal responsibility for determining, implementing and monitoring policies governing the hospice's total operation.

B. The Governing Body ~~must~~shall designate an individual who is responsible for the day-to-day management of the hospice program.

C. The Governing Body shall designate a medical director who assumes overall responsibility for the medical component of patient care.

D. The Governing Body's records shall reflect direct involvement in hospice policy development and oversight to include but not limited to:

1. Responsibilities of the administrator and medical director;

2. Management of contracted services;

3. Patient admission criteria;

4. Patient and family involvement in patient care planning;

5. An ongoing, comprehensive self-assessment of the quality of care provided to patients.

E. There ~~must~~shall be a schedule of not less than quarterly meetings during each calendar year and minutes shall be maintained of the meetings.

F. The Governing Body shall ensure:

1. ~~Make~~ Nursing services, physician services, drugs and biologicals are routinely available on a ~~twenty four~~ 24-hour basis;

- ~~2.~~ ~~Make~~ All ~~other~~ services ~~are~~ available on a ~~twenty-four~~ 24-hour~~s~~ basis to the extent necessary to meet the needs of ~~individuals~~ patients for care that is reasonable and necessary for the palliation and management of terminal illness and related conditions; and
- ~~3.~~ ~~The Governing Body must ensure a~~ All services provided are consistent with accepted standards of practice.

SECTION 7: PATIENT RIGHTS AND RESPONSIBILITIES

- A. A hospice shall inform and document that each patient, or when appropriate the patient's representative, has been informed of the following before or during the initial evaluation:
1. The patient shall be provided appropriate and professional quality services regardless of race, creed, color, religion, sex, national origin, sexual preference, disability or age, and to be free from physical abuse, mental abuse and/or neglect. The patient and property shall be treated with dignity and respect by all that provide services;
 2. The patient shall receive an explanation of the informed consent and election statement that is signed by the patient or patient's representative for the provision of hospice care;
 3. The patient shall participate in the decision-making process regarding where care is to be delivered and the options available;
 4. The patient shall receive a timely response from the hospice agency regarding any request for services;
 5. Privacy and confidentiality;
 6. The patient shall be informed of the name of the hospice agency, services offered by the agency, services being provided to the patient, and how to contact that agency during all hours;
 7. The patient shall be informed of the process of submitting and addressing complaints to the hospice agency and be informed of the address and phone number of the State Licensing Agency;
 8. The patient shall be informed that a hospice may not discontinue or diminish care because of the lack of a payor source; and
 9. The patient shall be informed orally and in writing, prior to service, of expected payment sources, i.e., Medicare, Medicaid, and various other payers.
 10. The patient shall be informed of services the hospice does not cover.
- B. The agency shall provide each patient and patient's representative with a list affirming the patient's and patient's representative's responsibility to:
1. Assist in developing and maintaining a safe environment, when possible;

2. Treat all agency staff with respect;
3. Participate in the development and update of the plan of care; and
4. Adhere to the plan of care as developed by the agency and assist in the care as necessary.

INFECTION CONTROL (Moved to Section 10)

Each hospice shall develop an infection control program which shall have as its purpose the protection of patient, family and personnel from hospice or community associated infection in patients admitted to the hospice, outpatient and home-care program.

GENERAL PROVISION

~~Implementation of rules, regulations and standards for hospice care in Arkansas shall be in general agreement with guidelines of the National Hospice Organization, the Arkansas State Hospice Association and the Health Care Finance Administration. Hospice providers not seeking certification for participation in Medicare reimbursement shall meet the Conditions of Participation for Hospice Care as set forth by the Department of Health and Human Services, Health Care Finance Administration, with certain exceptions to subparts A, B, and C of 42CFR. References to eligibility, election of benefits and reimbursement have been deleted.~~

~~(EDITOR'S NOTE: The following is edited for readability, i.e., to delete the exceptions to Medicare Conditions of Participation. The original version is available in the Division of Health Facility Services, Arkansas Department of Health. Edited July, 1987)~~

SECTION 8: ADMINISTRATION

A. Administration shall provide and document the following:

1. Job descriptions for all employees and volunteers;
2. Policies and procedures for each available service;
3. In-services pertinent to hospice care shall be ongoing for employees, volunteers, and contracted staff;
4. Orientation for all employees, volunteers and contracted staff; and
5. Annual review of policies and procedures.

B. Professional Management Services by Arrangement

A hospice may arrange for another individual or entity to furnish services to the ~~hospice's~~ patients. If services are provided under arrangement (i.e. under contract), the ~~hospice must meet the~~ following standards shall be met:

~~(a)~~1. Continuity of Care

The hospice program ~~assures~~ shall ensure the continuity of patient/family care in home, outpatient, and in-patient settings.

~~(b)~~2. Written Agreement

The hospice ~~has a legally binding~~ shall have a written agreement for the provision of ~~arranged-contracted~~ services. The ~~agreement-contract shall~~ includes at least the following:

~~(1)~~a) Identification of services to be provided; and

~~(6)~~b) ~~The~~ Qualifications of personnel providing the services.

~~(d)~~C. Inpatient care

The hospice ~~must~~shall have a written agreement approved with an area hospital, hospice in-patient facility, or qualified skilled nursing facility which states, that the hospice may continue to follow any hospice patient admitted to ~~their another~~ facility, ~~and supplement any in-patient care as indicated and approved by the attending physician during the patients in-patient stay and that medical record information will be furnished by each agency on hospice.~~

D. Continuation of Care

A hospice may not discontinue or diminish care because of the lack of a payor sourceinability to pay for that care.

E. Licensure

The hospice and all hospice employees mustshall be licensed in accordance with applicable Federal, State and local laws and regulations.

F. Core Services

A hospice must shall ensure that substantially all the core services (i.e., Nursing, Medical Social Services, Physician Services and Counseling) described in the following section are routinely provided directly by hospice employees. A hospice may use contracted staff if necessary to supplement hospice employees in order to meet the needs of patients during periods of peak patient loads or under extraordinary circumstances. If contracting is used, the hospice must shall maintain professional, financial, and administrative responsibility for the services and must shall assure the qualifications of staff and services provided meet the requirements specified for Nursing, Medical Social Services, Physician Services, and Counseling.

NOTE: Physician Services may be provided by an individual contract. The contract must specify the physician will assume all responsibilities as outlined in Section XI.A.

G. Post Mortem Procedures

The Hospice Agency shall have a procedure addressing post mortem procedures.

H. Pet Therapy

Pet Therapy may be provided by the hospice in the patient's home. Birds, cats, dogs, and other animals may be permitted in the patient's home. Therapy animals shall have appropriate vaccinations and licenses. A veterinary record shall be kept on all therapy animals to verify vaccinations and be made readily available for review and shall not negatively affect the well being of the patient.

I. Employee Health

It shall be the responsibility of Administration, with advice and guidance from the Medical Staff and the Infection Control Committee, to establish and enforce policies concerning pre-employment physicals and employee health. The policies shall include but are not limited to:

1. Requirements for an up-to-date health file for each employee;

2. Annual testing of each employee having direct patient contact for tuberculosis. Each employee having direct patient contact, regardless of whether the employee is a reactor, non-reactor, or converter, shall be tested or evaluated in accordance with the applicable section of the Tuberculosis Manual of the Arkansas Department of Health; and

3. Work restrictions shall be placed on personnel who are known to be affected with any disease in a communicable stage. Such individuals shall not work in any area in any capacity in which there is the likelihood of transmitting disease to patients, personnel or other individuals within the hospice or a potential of contaminating food, food contact surfaces, supplies or any surface with pathogenic organisms.

J. Complaints

Each agency shall keep a record of complaints received. Documentation shall include the name of the complainant, the relationship to the patient, the nature of the complaint, and the action taken to resolve the complaint.

J.K. Informed Consent.

An informed consent shall be signed by the patient or patient's representative for provision of hospice care.

L. Certification of Terminal Illness

The agency shall have certification signed by the physician stating the patient has a terminal illness.

M. Election of Hospice Care

~~(a)~~1. Duration of election. An election to receive hospice care will shall be considered to continue as long as the individual lives. patient remains in the care of a hospice or does not revoke the election for hospice care.

~~(b)~~2. Effective date of election. (1) An individual-patient or patient's representative may designate an effective date for the election period that beingsbegins with the first day of hospice care or any subsequent day of hospice care.

~~(c)~~3. Waiver of other benefits. An individual-patient or patient's representative

can elect hospice care from only one ~~(1)~~ hospice provider at any given time.

N. Elements of the Election Statement. The election statement ~~must~~shall include the following:

- ~~(a)~~1. Identification of the ~~particular~~ hospice that ~~will~~provides care to the ~~individual~~ patient;
- ~~(b)~~2. The ~~individual's patient's~~ or the patients representative's acknowledgment that he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to the ~~individual's patient's~~ terminal illness;
- ~~(c)~~3. The effective date of the election; and
- ~~(d)~~4. The signature of the ~~individual patient~~ or patient's representative.

O. Revoking the Election of Hospice Care

- ~~(a)~~1. An ~~individual patient~~ or patient's representative may revoke the ~~individual's patient's~~ election of hospice care at any time during an election period.
- ~~(b)~~2. To revoke the election of hospice care, the ~~individual patient~~ or patient's representative ~~must~~shall file a statement with the hospice that includes the following information:
 - ~~(1)~~a) A signed statement that the ~~individual patient~~ or patient's representative revokes the ~~individual's patient's~~ election for hospice care.
 - ~~(2)~~b) The date the revocation is effective. (A ~~individual patient~~ or patient's representative may not designate an effective date earlier than the date that the revocation is made).

CERTIFICATION OF TERMINAL ILLNESS (Moved to Section 8, L)

~~A. Obtaining certification. The hospice must obtain the certification that an individual is terminally ill. The hospice obtains, no later than two (2) calendar days after hospice care is initiated, written certification statements, signed by:~~

- ~~1. The medical director of the hospice or the physician member of the hospice interdisciplinary group; and~~

~~2. The individual=s attending physician if the individual has an attending physician.~~

~~B. Certification statement. The certification must include:~~

~~1. The statement that the individual=s medical prognosis is that his or her life expectancy is six (6) months or less; and~~

~~2. The signatures(s) of the physician(s) required to certify the terminal illness.~~

~~C. Maintaining a record. The hospice maintains the certification statements.~~

ELECTION OF HOSPICE CARE [\(Moved to Section 8, M\)](#)

(a) Duration of election. An election to receive hospice care will be considered to continue as long as the individual lives. [\(Moved to Section 8, M1\)](#)

~~1. Remains in the care of a hospice; and~~

~~2. Does not revoke the election for hospice care.~~

(b) Effective date of election. (1) An individual or representative may designate an effective date for the election period that begins with the first day of hospice care or any subsequent day of hospice care. [\(Moved to Section 8, M2\)](#)

(c) Waiver of other benefits. An individual can elect hospice care from only one (1) hospice provider at any given time. [\(Moved to Section 8, M3\)](#)

ELEMENTS OF THE ELECTION STATEMENT [\(Moved to Section 8, N\)](#)

The election statement must include the following:

(a) Identification of the particular hospice that will provide care to the individual.

(b) The individual's or representative's acknowledgment that he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to the individual's terminal illness.

(c) The effective date of the election.

(d) The signature of the individual or representative.

REVOKING THE ELECTION HOSPICE CARE [\(Moved to Section 8, O\)](#)

- (a) An individual or representative may revoke the individual's election of hospice care at any time during an election period.
- (b) To revoke the election of hospice care, the individual or representative must file a statement with the hospice that includes the following information:
 - (1) A signed statement that the individual or representative revokes the individual's election for hospice care.
 - (2) The date that the revocation is to be effective. (An individual or representative may not designate an effective date earlier than the date that the revocation is made).

CHANGE OF THE DESIGNATED HOSPICE

- ~~(a) An individual or representative may change, once as long as he lives, the designation of the particular hospice from which hospice care will be received.~~
- ~~(b) The change of the designated hospice is not considered a revocation of hospice care.~~
- ~~(c) To change the designation of hospice programs, the individual or representative must file, with the hospice from which care has been received and with the newly designated hospice, a statement that includes the following information:
 - ~~(1) The name of the hospice from which the individual has received care and the names of the hospice from which he or she plans to receive care.~~
 - ~~(2) The date the change is to be effective.~~~~

ADMINISTRATION: GENERAL PROVISIONS

- ~~(a) Compliance. A hospice must maintain compliance with all the following sections, through "Short Term Inpatient Care". A freestanding hospice that provides inpatient services directly must also maintain compliance with the Section titled, "Free Standing Hospices Providing Inpatient Care Directly".~~
- ~~(b) Required services. A hospice must be primarily engaged in providing the care and services described in this document including bereavement counseling, and must:
 - (1) Make nursing services, physician services, and drugs and biologicals routinely available on a twenty-four (24) hour basis; [\(Moved to Section 6, F1\)](#)
 - (2) Make all services available on a twenty-four (24) hours basis to the extent necessary to meet the needs of individuals for care that is reasonable and~~

necessary for the palliation and management of terminal illness and related conditions; and [\(Moved to Section 6, F2\)](#)

- (3) Provide these services in a manner consistent with accepted standards of practice. [\(Moved to Section 6, F3 with minor changes\)](#)

~~(c). [Disclosure of information.](#) The hospice must meet the disclosure of information requirements.~~

GOVERNING BODY [\(Moved to Section 6, A, B and F3 \)](#)

A hospice must have a governing body that assumes full legal responsibility for determining, implementing and monitoring policies governing the hospice's total operation.

The governing body must designate an individual who is responsible for the day to day management of the hospice program.

The governing body must also ensure that all services provided are consistent with accepted standards of practice.

MEDICAL DIRECTOR [\(Moved to Section 11\)](#)

~~The medical director must be a hospice employee who is a doctor of medicine or osteopathy who assumes overall responsibility for the medical component of the hospice's patient care program.~~

PROFESSIONAL MANAGEMENT [\(Moved to New Section 8, B\)](#)

A hospice may arrange for another individual or entity to furnish services to the hospice's patients. If services are provided under arrangement (i.e., under contract), the hospice must meet the following standards:

- (a) Continuity of Care. The hospice program assures the continuity of patient/family care in home outpatient, and inpatient settings. [\(Moved to new Section 8, B1\)](#)
- (b) Written agreement. The hospice has a legally binding written agreement for the provision of arranged services. The agreement includes at least the following: [\(Moved to new Section 8, B2\)](#).

- (1) Identification of the services to be provided. [\(Moved to new Section 8, B2a\)](#)

~~(2) A stipulation that services may be provided only with the express authorization of the hospice.~~

~~(3) The manner in which the contracted services are coordinated, supervised,~~

~~and evaluated by the hospice.~~

~~(4) The delineation of role(s) of the hospice and the contractor in the admission process, patient/family assessment, and the interdisciplinary group care conferences.~~

~~(5) Requirements for documenting that services are furnished in accordance with the agreement.~~

(6) The qualifications of the personnel providing the services. [\(Moved to new Section 8, B2b\)](#)

~~(c) Professional management responsibility. The hospice retains professional management responsibility for those services and ensures that they are furnished in a safe and effective manner by persons meeting the qualifications of this part, and in accordance with the patient=s plan of care and the other requirements of this part.~~

(d) Inpatient care. The hospice must have a written agreement approved with area inpatient facilities which states, that the hospice may continue to follow any hospice patient admitted to their facility, and supplement any inpatient care as indicated and approved by the attending physician during the patients inpatient stay and that medical record information will be furnished by each agency on hospice. [\(See Section 8, C\)](#)

PLAN OF CARE [\(Moved to Section 18\)](#)

A written plan of care must be established and maintained for each individual admitted to a hospice program, and the care provided to an individual must be in accordance with the plan.

(a) Establishment of plan. The plan must be established by the attending physician, the medical director or physician designee and interdisciplinary group prior to providing care.

(b) Review of plan. The plan must be reviewed and updated, at intervals specified in the plan, by the attending physician, the medical director or physician designee and interdisciplinary group. These reviews must be documented.

(c) Content of plan. The plan must include assessment of the individual's needs and identification of the services including the management of discomfort and symptom relief. It must state in detail the scope and frequency of services needed to meet the patient's and family's needs.

CONTINUATION OF CARE [\(Moved to Section 8, D\)](#)

A hospice may not discontinue or diminish care because of inability to pay for that care.

INFORMED CONSENT [\(Moved to Section 8, K\)](#)

~~A hospice must demonstrate respect for an individual's rights by ensuring that an informed consent form that specifies the type of care and services that may be provided as hospice care during the course of the illness has been obtained for every individual, either from the individual or representative.~~

INSERVICE TRAINING

~~A hospice must provide an ongoing program for the training of its employees.~~

SECTION 9: QUALITY ASSURANCE IMPROVEMENT (QI)

A. The organization shall develop, implement, and maintain an ongoing program to assess and improve the quality of care and services provided. A Quality Improvement (QI) plan shall be developed and maintained to describe the manner in which QI activities shall be conducted. The QI plan shall be reviewed and approved by the Medical Staff and Governing Body annually.

1. All hospice programs, services, departments and functions, including contracted services related to patient care, shall participate in ongoing quality improvement activities.
2. The hospice shall collect and assess data on the functional activities identified as priorities in the QI plan.
3. Improvement strategies shall be developed for programs, services, departments and functions identified with opportunities for improvement.
4. The effectiveness of improvement strategies and actions taken shall be monitored and evaluated, with documentation of conclusions regarding effectiveness.

B. The QI program shall include, but not be limited to, ongoing assessment and improvement activities regarding the following:

1. Access to care, processes of care, outcomes of care and hospice-specific clinical data;
2. Customer satisfaction (patients and families, physicians, and employees);
3. Organizational performance.

QUALITY ASSURANCE (Moved to Section 9)

~~A hospice must conduct an ongoing, comprehensive, integrated, self-assessment of the quality and appropriateness of care provided, including inpatient care, home care and care provided under arrangements. The findings are used by the hospice to correct identified problems and to revise hospice policies if necessary. Those responsible for the quality assurance program must B~~

~~(a) Implement and report on activities and mechanisms for monitoring the quality of patient care;~~

~~(b) Identify and resolve problems; and~~

~~(c) — Make suggestions for improving patient care.~~

SECTION 10: INFECTION CONTROL

Each hospice shall develop an infection control program which ~~shall have as its purpose the protection of~~ protects patients, family and personnel from ~~hospice or community associated infection in patients admitted to the hospice, outpatient and home care program~~ nosocomial or community acquired infections.

- A. The hospice shall develop and use a coordinated process that effectively reduces the risk of endemic and epidemic nosocomial infections in patients, health care workers and visitors.
- B. It shall be the duty of the Administrator or his/her designee to report all known infectious or communicable diseases as required by Ark. Code Ann. § 20-7-109 to the Arkansas Department of Health, Division of Epidemiology.
- C. There shall be policies and procedures establishing and defining a comprehensive Infection Control program to include:
 - 1. Provisions for education of universal precautions to patients, families, and hospice employees including but not limited to:
 - a) Hand hygiene including procedures for soap and water as well as alcohol based hand rub if used;
 - b) Disinfections;
 - c) Liquid and solid waste disposal of infectious waste;
 - d) Needle disposal; and
 - e) Other means of limiting the spread of contagion.
 - 2. A plan for monitoring and evaluating all aseptic and sanitation techniques employed in the hospice to ensure that approved infection control procedures are followed.
- D. There shall be an orientation program for all new health care workers concerning the importance of infection control and each health care worker's responsibility in the infection control program.
- E. There shall be a plan for each employee to receive annual in-services and educational programs as indicated based on assessments of the infection control process.
- F. No items shall be used past the expiration date.

G. One time patient care items shall not be reused.

SECTION 11: PHYSICIAN SERVICES

A. Medical Director

The overall responsibility for the medical component of patient care shall be under the direction of a physician, qualified by training and experience in hospice care, who shall also be responsible for no less than the following:

1. Ensuring and maintaining quality standards of medical practice;
2. Achievement and maintenance of quality assurance of medical practices through a mechanism for the assessment of patient/family care outcomes;
3. Certification of terminally ill patients admitted to the hospice program;
4. Participation as a member of the interdisciplinary team, in the development, implementation and assessment of patient/family plan of care; and
5. Consulting with the attending physician regarding patient care plans.

B. Physician Services

1. Physician Services shall be provided in accordance with hospice policies.
2. Such policies shall include provisions governing the relationship of the staff physicians, attending physician and the Medical Director to each other, and to the interdisciplinary team.
3. In addition to palliation and management of terminal illness and related conditions, physician employees of the hospice, including the physician member(s) of the interdisciplinary group, must also meet the general medical needs of the patients to the extent that these needs are not met by the attending physician.

INTERDISCIPLINARY GROUP (Moved to Section 13)

~~The hospice must designate an interdisciplinary group or groups composed of individuals who provide or supervise the care and services offered by the hospice.~~

Moved to Section 13, A)

(a) Composition of group. The hospice must have an interdisciplinary group or groups that include at least the following individuals who are employees of the hospice:

- (1) A doctor of medicine or osteopathy.**

- (2) A registered nurse.
- (3) A social worker.
- (4) A pastoral or other counselor.

Moved to Section 13, B)

(b) Role of group. The interdisciplinary group is responsible for --

- (1) Participation in the establishment of the plan of care;
- (2) Provision of supervision of hospice care and services;
- (3) Periodic review and updating of the plan of care for each individual receiving hospice care; and
- ~~(4) Establishment of policies governing the day-to-day provision of hospice care and services.~~

~~(c) If a hospice has more than one interdisciplinary group, it must designate in advance the group it chooses to execute the functions described in paragraph (b) (4) of this section.~~

~~(d) Coordinator. The hospice must designate a registered nurse to coordinate the implementation of the plan of care for each patient.~~

VOLUNTEERS (Moved to Section 14)

~~The hospice in accordance with the numerical standards, specified in paragraph (e) of this section, uses volunteers, in defined roles, under the supervision of a designated hospice employee.~~

(Moved to Section 14, A and B)

(a) Training. The hospice must provide appropriate orientation and training that is consistent with acceptable standards of hospice practice.

(b) Role. Volunteers must be used in administrative or direct patient care roles.

~~(c) Recruiting and retaining. The hospice must document active and ongoing efforts to recruit and retain volunteers.~~

(Moved to Section 14, C)

(d). Level of activity. A hospice must document and maintain a volunteer staff sufficient to provide administrative or direct patient care in an amount that, at a minimum,

equals 5 percent of the total patient care hours of all paid hospice employees and contract staff. The hospice must document a continuing level of volunteer activity. Expansion of care and services achieved through the use of volunteers, including the type of services, and the time worked, must be recorded.

~~(e) Availability of clergy. The hospice must make reasonable efforts to arrange for visits of clergy and other members of religious organizations in the community to patients who request such visits and must advise patients of this opportunity.~~

LICENSURE (Moved to Section 8.E)

The hospice and all hospice employees must be licensed in accordance with applicable Federal, State and local laws and regulations.

~~A. Licensure of program. If State or local law provides for licensing of hospices, the hospice must be licensed.~~

~~B. Licensure of employees. Employees who provide services must be licensed, certified or registered in accordance with applicable Federal or State laws.~~

CENTRAL CLINICAL RECORDS (Moved to Section 19)

In accordance with accepted principles of practice, the hospice must establish and maintain a clinical record for every individual receiving care and services. The record must be complete, promptly and accurately documented, readily accessible and systematically organized to facilitate retrieval.

(a) Content. Each clinical record is a comprehensive compilation of information. Entries are made for all services provided. Entries are made and signed by the person providing the services. The record should include all services whether furnished directly or under arrangements made by the hospice. Each individual's record contains –

- (1) The initial and subsequent assessments;
- (2) The plan of care;
- (3) Identification date;
- (4) Consent and authorization and election forms;
- (5) Pertinent medical history; and
- (6) Complete documentation of all services and events (including evaluations, treatments, progress notes, ect.).

- (b) Protection of information. The hospice must safeguard the clinical record against loss, destruction and unauthorized use.

CORE SERVICES([Moved to Section 8, F](#))

A hospice must ensure that substantially all the core services (i.e., Nursing, Medical Social Services, Physician Services and Counseling) described in the following section are routinely provided directly by hospice employees. A hospice may use contracted staff if necessary to supplement hospice employees in order to meet the needs of patients during periods of peak patient loads or under extraordinary circumstances. If contracting is used, the hospice must maintain professional, financial, and administrative responsibility for the services and must assure that the qualifications of staff and services provided meet the requirements specified for Nursing, Medical Social Services, Physician Services, and Counseling.

SECTION 12: NURSING SERVICES

~~The hospice must provide nursing care and services by or under the supervision of a registered nurse.~~

~~(a) Nursing services must be directed and staffed to assure that the nursing needs of patients are met.~~

~~A. A registered nurse shall assign the nursing care of each patient to other personnel in accordance with the patient's needs.~~

~~(b) Patient care responsibilities of nursing personnel must be specified.~~

~~B. A registered nurse shall plan, supervise and evaluate the care for each patient.~~

~~(c)C. Nursing Sservices must shall be provided in accordance with recognized standards of practice.~~

SECTION 13: INTERDISCIPLINARY GROUP

The Interdisciplinary Group or groups shall be composed of individuals who provide or supervise the care and services offered by the hospice.

~~(a)~~A. Composition of Group

The ~~hospice must have an~~ interdisciplinary group or groups ~~that shall~~ include at least the following individuals ~~who are employees of the hospice~~:

1. A doctor of medicine or osteopathy;
2. A registered nurse;
3. A social worker; and
4. A ~~pastoral~~minister or other ~~counselor~~ clergy.

~~(b)~~B. Role of Group

The interdisciplinary group ~~is responsible for~~: shall:

1. ~~Participation~~Participate in the establishment of the plan of care;
2. ~~Provision~~Provide of supervision of hospice care and services;
3. Periodically review and updating ~~of~~ the plan of care to reflect the needs of ~~for~~ each ~~individual~~ patient receiving hospice care. ~~;~~ and

SECTION 14: VOLUNTEERS

The hospice shall use volunteers, in defined roles, under the supervision of a designated hospice employee. The hospice shall maintain documentation of active and ongoing efforts to recruit and retain volunteers.

(a)A. Training

~~The hospice must provide appropriate~~ Orientation and training ~~that is~~ shall be provided consistent with acceptable standards of hospice practice.

(b)B. Role

Volunteers must be used in administrative services or direct patient care.

(d)C. Level of Activity

A hospice ~~must shall document and~~ maintain a volunteer staff sufficient to provide administrative or direct patient care ~~in an amount that,~~ at a minimum, that equals five 5 percent of the total patient care hours of all paid hospice employees and contract staff. The hospice ~~must shall document maintain~~ a continuing level of volunteer activity. Expansion of care and services achieved through the use of volunteers, including the type of services, and the time worked, must shall be recorded.

D. Employees as Volunteers

Hospice employees may be used as volunteers only after completing a hospice volunteer training program.

MEDICAL SOCIAL SERVICES (Moved to new Section 15, D)

Medical social services must be provided by a qualified social worker, under the direction of a physician.

PHYSICIAN SERVICES (Moved to Section 11)

In addition to palliation and management of terminal illness and related conditions, physician employees of the hospice, including the physician member(s) of the interdisciplinary group, must also meet the general medical needs of the patients to the extent that these needs are not met by the attending physician.

SECTION 15: COUNSELING SERVICES

Counseling services ~~must shall~~ be available to ~~both~~ the ~~individual patient~~ and the family: ~~and shall~~. ~~Counseling includes bereavement counseling, provided after the patient's death as well as dietary, spiritual and any other counseling services for the individual and family provided while the individual is enrolled in the hospice~~ the following:

~~(a)~~A. Bereavement ~~counseling~~ Services

There ~~must shall~~ be an organized program for provision of bereavement services under the supervision of ~~a qualified professional, an individual with specialized bereavement training.~~ The plan of care for these services should shall reflect family needs as well as a clear delineation of services to be provided and the frequency of service delivery (up to one year following the death of the patient) which shall include personal visits up to one year following the patients death. Refusal or variations from the visits or contacts shall be documented.

~~(b)~~B. Dietary Counseling

~~Dietary counseling, when required must be provided by a qualified individual. A qualified dietitian shall provide dietary counseling, when required.~~

~~(c)~~C. Spiritual Counseling

~~Spiritual counseling must include notice to patients as to the availability of clergy. The hospice shall notify the patient of the opportunity for spiritual counseling either from the hospice clergy or clergy of the patient's choice. If the patient elects to have his/her clergy visit, the hospice shall make reasonable efforts to arrange for the visit(s).~~

~~(d)~~D. ~~Additional counseling~~ Social Services

~~Counseling may be provided by other members of the interdisciplinary group as well as by other qualified professionals as determined by the hospice.~~ Social Services shall be provided by a qualified Social Worker.

SECTION 16: OTHER SERVICES

A hospice ~~must~~shall ensure the following services are available and provided directly by hospice employees or under arrangement ~~(i.e., contracts) made by the hospice as specified under the “Professional Management” section~~ and offered in a manner consistent with acceptable standards of practice;

- A. Physical Therapy;
- B. Occupational Therapy; and
- C. Speech-Language Pathology.

PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH-LANGUAGE PATHOLOGY(See above)

~~Physical therapy services, and speech language pathology services must be available and when provided, offered in a manner consistent with acceptable standards of practice. Occupational therapy must be provided if needed and available in the service area.~~

SECTION 17: HOSPICE AIDE AND HOMEMAKER SERVICES

- A. Hospice ~~Home Health~~ aide and homemaker services ~~must shall~~ be available and adequate in frequency to meet the needs of the patients. A hospice home health aide is a person who meets ~~the training, attitude and skill requirements specified in the following section~~ at least one of the following requirements:
1. Has at least one year of experience in an institutional setting (home health agency, hospital, hospice, or long-term care facility). This experience shall be verified by a previous employer;
 2. Has a certificate issued by the State of Arkansas for work in long-term care facilities. A copy of this certificate shall be available for review; or
 3. Has completed a 40-hour aide training course that meets requirements set forth in these regulations. In lieu of the requirement for completion of the hospice aide training course, a nursing student may qualify as a hospice aide by submitting documentation from the Director of Programs and/or the Dean of a School of Nursing that reflects the nursing student has demonstrated competency in providing basic nursing care in accordance with the school's curriculum.
- B. Any aide who has not been employed as an aide in an institutional setting in the last 24 months shall be observed by a registered nurse performing the skills required to care for a patient including bathing, transferring, range of motion exercises, toileting, dressing, nail care and skin care. The registered nurse shall observe the aide performing these skills on a person. Any other tasks or duties for which the aide may be responsible shall be evaluated by written test, oral test or observation. There shall be documentation by the agency to show evidence of this evaluation.
- C. A registered nurse shall complete an aide assignment sheet for each patient receiving aide services. Each aide caring for the patient shall receive a copy of the assignment sheet and provide services as assigned. A copy of the assignment sheet shall be left in the patient's home and in the patient's medical record.
- D. Each aide assignment sheet shall be individualized and specific according to the patient's needs.
- E. The registered nurse shall conduct a visit to the patient's place of residence at least every two weeks to supervise the aide and update the aide assignment sheet.
- F. In no event shall a hospice aide receive or write verbal orders from a physician. A hospice aide shall not perform any sterile procedure or any procedure requiring the application of medication requiring a prescription.

- G. Upon a request by a patient and/or family member for assistance with medications, the registered nurse may assign a hospice aide to assist with oral medications, which are normally self-administered. Assistance shall be limited to reminding a patient to take a medication at a prescribed time, opening and closing a medication container and returning a medication to a proper storage area.
- H. Except as otherwise provided in these rules, duties of the hospice aide may include:
1. Personal care (example: bathing, grooming, feeding, ambulation, exercise, oral hygiene, and skin care, etc.);
 2. Assistance with medications ordinarily self-administered as assigned;
 3. Household services essential to health care in the home;
 4. Completion of records and reporting to appropriate supervisor;
 5. Taking and charting vital signs;
 6. Extension of therapy services; and
 7. Any duty consistent with the State Board of Nursing Regulations on Delegation of Duties may be assigned by a registered nurse to meet the needs of the patient.
- I. If the training is provided by the agency, the training program for hospice aides shall be conducted under the supervision of a registered nurse. The training program may contain other aspects of learning, but shall include the following:
1. A minimum of 40 hours of classroom and clinical instruction related particularly to the hospice setting;
 2. Written course objectives with expected outcomes and methods of evaluation; and
 3. An assessment that the student knows how to read and write and to carry out directions.
- J. Course and clinical work content shall include, but not be limited to, orientation to hospice philosophy, bathing, ambulation and exercise, personal grooming, principles of nutrition and meal preparation, health conditions, developmental stages and mental status, household services essential to health care at home, assistance with medication, safety in the home, completion of appropriate records and reporting changes to appropriate supervisor.

K. Aides shall receive a minimum of 12 hours in-service training per 12 months. The in-services provided shall address areas that directly relate to the patient care aspects of the aides' job.

L. Homemaker services shall be available and adequate in frequency to meet the patient's needs.

HOME HEALTH AIDE SERVICES

~~Home health aides are selected on the basis of such factors as a sympathetic attitude toward the care of the sick, ability to read, write, and carry out directions, and maturity and ability to deal effectively with the demands of the job. Aides are carefully trained in methods of assisting patients to achieve maximum self reliance, principles of nutrition and meal preparation, the aging process and emotional problems of illness, procedures for maintaining clean, healthful; and pleasant environment, changes in patient=s condition that should be reported, work of agency and health team, ethics, confidentiality, and recordkeeping. They are closely supervised to assure their competence in providing care.~~

~~(a). Assignment and duties of the home health aide. The home health aide is assigned to a particular patient by a registered nurse. Written instructions for patient care are prepared by a registered nurse or therapist as appropriate. Duties include the performance of simple procedures as an extension of therapy services, personal care, ambulation and exercise, household services essential to health care at home, assistance with medications that are ordinarily self-administered, reporting changes in the patient's conditions and needs; and completing appropriate records.(See Section XVII).~~

~~(b). Supervision. The registered nurse or appropriate professional staff member, if other services are provided, makes a supervisory visit to the patient=s residence at least every two (2) weeks, either when the aide is present to observe and assist, or when the aide is absent, to assess relationships and determine whether goals are being met.(See Section XVII).~~

SECTION 18: PLAN OF CARE

A written plan of care ~~must~~shall be established, ~~and maintained, and provided~~ for each ~~individual~~patient admitted to a hospice program ~~and the care provided to an individual must be in accordance with the plan.~~ ~~(c) Content of plan.~~ The plan ~~must~~shall include an assessment of the ~~individual's~~patient's needs and identification of the services including the management of discomfort and symptom relief. It ~~must~~shall state in detail the scope and frequency of services needed to meet the patient's and family's needs. A written plan of care shall be:

- ~~(a)~~A. ~~Establishment of a plan. The plan must be established~~ Developed by the attending physician, the medical director ~~or physician designee~~ and interdisciplinary group prior to providing care; and
- ~~(b)~~B. ~~Review of plan. The plan must be r~~Reviewed and ~~updated~~ revised, ~~at intervals specified in the plan, to reflect the patient and family's current needs,~~ by the attending physician, the medical director ~~or physician designee~~, and interdisciplinary group. The reviews ~~must~~ shall be documented.

SECTION 19: CLINICAL RECORDS

In accordance with accepted principles of practice, the hospice ~~must~~shall establish and maintain a clinical record for every ~~individual-patient~~ receiving care and services. The record ~~must~~shall be complete, ~~promptly and accurately documented~~, readily accessible and systematically organized to facilitate retrieval.

~~(a)~~A. Content

~~Each clinical record is a comprehensive compilation of information.~~ Entries ~~are~~shall be made ~~for all the day~~ services are provided. Entries shall be signed by the person providing the services. All entries shall be legible and readily accessible. The record ~~should~~shall include all services whether furnished directly or under arrangements ~~made by the hospice~~. Each ~~individual's-patient's~~ record shall contain the following:

1. ~~The i~~Initial and subsequent assessments;
2. ~~The p~~Plan of care;
3. Identification data;
4. Consent, ~~and~~ authorization, and election forms;
5. Pertinent medical history; and
6. ~~Completed~~Documentation of all services and events ~~(including evaluations, treatments, progress notes, etc.)~~.

~~(b)~~B. Protection of Information

The hospice ~~must~~shall use reasonable precautions ~~-safeguard to~~ safeguard the clinical record against loss, destruction and unauthorized use.

C. Record Retention

Closed records shall be retained for a minimum of five years.

SECTION 20: MEDICAL SUPPLIES/MEDICATIONS

Medical supplies, appliances, ~~including~~ drugs and biologicals, ~~must shall~~ be provided as needed for the palliation and management of the terminal illness and related conditions.

~~(a)~~A. Administration

All drugs and biologicals ~~must shall~~ be administered in accordance with accepted standards of practice.

~~(b)~~B. Controlled Drugs in the Patient's Home

~~The hospice must have a policy for the disposal of controlled drugs maintained in the patient's home when those drugs are no longer needed by the patient. Controlled substances no longer required by a patient receiving in-home hospice services may be disposed of by the owner of the prescription or a family member of a deceased patient to whom the controlled substances were dispensed. If requested, the controlled substances may be disposed of in the presence of a hospice nurse in which case the nurse shall document the disposal by completing the Report of Drugs Surrendered Form and returns to Pharmacy Services and Drug Control, Arkansas Department of Health. The patient or family member shall keep the blue copy of the Report of Drugs Surrendered Form while the nurse places the yellow copy in the medical record and returns the white copy to Pharmacy Services and Drug Control, Arkansas Department of Health.~~

~~(c)~~C. Administration of Pharmaceuticals ~~Pharmaceuticals are administered only by the following individuals:~~

- ~~1. — A licensed nurse or physician.~~
- ~~2. — The patient if his or her attending physician has approved.~~

~~A licensed nurse, physician, patient or caregiver shall administer pharmaceuticals.~~

SECTION 21: SHORT-TERM INPATIENT CARE

Inpatient care ~~must~~ shall be available for pain control, symptom management, respite purposes, and shall be provided in licensed facilities, as stated below:

(a)A. Inpatient Care for Symptom Control

Inpatient care for pain control and symptom management ~~must~~ shall be provided in one of the following:

- ~~(1).~~ A hospice that meets the requirements for providing inpatient care directly as specified in the Section, ~~“Free Standing Hospices Providing inpatient care directly as specified in the section;”~~ “Inpatient Direct Care”, Section 22.
- ~~(2).~~ A hospital or a Skilled Nursing Facility (SNF). ~~that also meets the requirements specified for nursing service and patient areas. (See paragraphs (a) twenty four (24) hour nursing services, and (f) patient areas; A Freestanding Hospices Providing Inpatient Care Directly”.)~~
- 3). Each shift shall include a registered nurse on site to supervise and provide direct patient care.

(b)B. Inpatient Care for Respite Purposes

Inpatient care for respite purposes ~~must~~ shall be provided by one of the following:

- ~~(1).~~ ~~A provider specified in paragraph (a) of this section.~~ A hospice that meets the requirements for providing inpatient care directly as specified in the Section, “Inpatient Direct Care”, Section 22.
- ~~(2).~~ ~~An Intermediate Care Facility (ICF) that also meets the requirements specified under “Free Standing Hospices Providing Inpatient Care Directly” paragraphs (a) and (f) regarding twenty four (24) hour nursing service and patient areas.~~ A hospital or a Skilled Nursing Facility (SNF).

SECTION 22: FREE STANDING HOSPICE PROVIDING INPATIENT CARE DIRECTLY IN-PATIENT DIRECT CARE

~~A freestanding hospice that provides inpatient care directly must comply with all of the following standards.~~

In addition to the preceding sections, In-patient Direct Care shall also comply with Sections 22 through 33.

A. Administration shall be responsible for the following:

1. Policies and procedures shall be provided for the general administration of the institution and for each department, section or service in the facility. All policies and procedures for departments or services shall have evidence of ongoing review and/or revision. The first page of each manual shall have the annual review date, signature of the department supervisor and/or person(s) conducting the review.
2. The facility shall have visitation policies determined by the Medical Staff, Governing Body and Administration. Patients shall be permitted to receive visitors at any hour, including small children.
3. An emergency medication kit approved by the Pharmaceutical Services Committee shall be readily available. The integrity of the seal on the kit shall be checked each shift by licensed personnel.
4. Disaster Preparedness

A written disaster preparedness plan shall be developed and communicated to staff through orientation, education and ongoing reviews. The plan shall include:

- a) A definition of "disaster" for the hospice inpatient facility's given location and circumstances;
- b) Arrangements for prompt identification and transfer of patients and records to another facility if necessary;
- c) Arrangements for coordination of community resource; and
- d) Menus to coincide with a 24-hour supply of perishable and 72 hours supply for non-perishable food available for emergencies.

~~(a) Twenty-four (24) hour nursing services.~~

B. Nursing

- ~~(1).~~ The facility shall ~~provides twenty four (24) hour nursing services which are sufficient to meet patient total nursing needs and which are~~ in accordance with the patient plan of care. Each patient receives treatments, medications, and diet as prescribed, and is kept comfortable, clean, well-groomed, and protected from accident, injury, and infection.
- ~~(2).~~ Each shift must shall include a registered nurse ~~who provides direct patient care;~~ on site to supervise and provide direct patient care and one other nursing personnel type (e.g. RN, LPN and/or hospice aide.) A ratio of at least 1 nursing personnel to each 4 patients shall be maintained.
3. A registered nurse shall assign the patient care of each patient to other personnel in accordance with the patient's needs.
- ~~(b) Disaster preparedness. (Moved to Section 22, A, 4) The hospice has an acceptable written plan, periodically rehearsed with staff, with procedures to be followed in the event of an internal or external disaster and for the care of casualties (patients and personnel) arising from such disasters.~~
- ~~(c) Health and safety laws. The hospice must meet all Federal, State, and local laws, regulation, and codes pertaining to health and safety, such as provisions regulating:~~
 - ~~1. Construction, maintenance, and equipment for the hospice; (See Section 24)~~
 - ~~2. Sanitation; (See Section 34, B)~~
 - ~~3. Communicable and reportable diseases; and (See Section 10, B)~~
 4. Post mortem procedures. (Moved to Section 8,G)
- ~~(d) Fire protection. The hospice must meet the health care occupancy provisions of the 1981 edition of the Life Safety Code of the National Fire Protection Association. (See Section 32, C)~~
- ~~(f) Patient areas (See Section 26, A)~~
 - ~~(1) The hospice must design and equip areas for the comfort and privacy of each patient and family members.~~
 - ~~(2) The hospice must have:~~
 - ~~(i) Physical space for private patient/family visiting;~~

- ~~(ii) — Accommodation for family members to remain with the patient throughout the night;~~
- ~~(iii) — Accommodations for family privacy after a patient=s death;~~
- ~~(iv) — Decor -which is homelike in design and function.~~

(3) Patients must be permitted to receive visitors at any hour, including small children. [\(See Section 22, A, 2\)](#)

~~(g) — Patient rooms and toilet facilities. Patient rooms are designed and equipped for adequate nursing care and the comfort and privacy of patients. [\(See Section 26,A\)](#)~~

~~(1) — Each patient's room must --~~

- ~~(i) — Be equipped with or conveniently located near toilet and bathing facilities;~~
- ~~(ii) — Be at or above grade level;~~
- ~~(iii) — Contain a suitable bed for each patient and other appropriate furniture;~~
- ~~(iv) — Have closet space that provides security and privacy for clothing and personal belongings;~~
- ~~(v) — Contain no more that four beds;~~
- ~~(vi) — Measure at least 100 square feet for a single patient room or 80 square feet for each patient for a multipatient room; and~~
- ~~(vii) — Be equipped with a device for calling the staff member on duty.~~

~~(h) — Bathroom facilities. The hospice must:(Section 26)~~

~~(1) — Provide an adequate supply of hot water at all times for patient use; and~~

~~(2) — Have plumbing fixtures with control valves that automatically regulate the temperature of the hot water used by patients.~~

(i). Linen. The hospice has available at all times a quantity of linen essential for proper care and comfort of patients. Linens are handled, stored, processed, and transported in such a manner as to prevent the spread of infection. [Moved to Section 22, E\)](#)

(j). Isolation areas. The hospice must make provision for isolating patients with infectious diseases. (See Section 23, A and B)

C. Dietary

(k) Meal service, menu planning and supervision. The hospice must shall:

~~(1).~~ Serve at least three (3) meals or their equivalent each day at regular times, with not more than fourteen (14) hours between a substantial evening meal and breakfast. Meals may be adjusted according to the request and as tolerated by the patient;

~~(2).~~ Procure, store, prepare, distribute and serve all food under sanitary conditions in accordance with the current Rules and Regulations Pertaining to Food Establishments.

~~(3).~~ Have a staff member trained or experienced in food management and nutrition. Employ a registered dietician or have a formal agreement with a registered dietician who is responsible for:

~~(i)~~ Planning menus that meet nutritional needs of each patient, following the orders of the patient's physician and, to the extent medically possible, the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences Recommended Dietary Allowances (9th ed., 1981) is available from the Printing and Publications Office, National Academy of Sciences, Washington, DC 20416); in accordance with the recommended dietary allowances of the Food Nutrition Board of the National Research Council, National Academy of Sciences; and

~~(ii)~~ Supervising the meal preparation and service to ensure the menu plan is followed; ~~and~~

~~(4).~~ If the hospice has patients who require medically prescribed special diets, have the menus for those patients planned by a professionally qualified dietitian and supervise the preparation and serving of meals to ensure that the patient accepts the special diet. Have therapeutic menus prepared by a registered dietitian for patients who require medically prescribed special diets.

5. Have bedtime and between meal snacks or supplements available.

~~(1)D.~~ Pharmaceutical ~~hospice~~ Service

~~The hospice provides a~~Appropriate methods and procedures for the dispensing and administering of drugs and biologicals shall be developed. Whether drugs and biologicals are obtained from community or institutional pharmacists or stocked by the facility, the facility is responsible for drugs and biologicals for patients, in so far as they are covered under the program and for ensuring that pharmaceutical services are provided in accordance with accepted professional principles and appropriate Federal, State and local laws.

~~(1).~~ ~~Licensed pharmacist:~~The Hospice ~~must~~ shall:

- ~~(i)a)~~ Employ a licensed pharmacist; or
- ~~(i)b)~~ Have a formal agreement with a licensed pharmacist to advise the hospice on ordering, storage, administration, disposal, and record keeping of drugs and biologicals; and
- c) Have a Pharmaceutical Service Committee which meets quarterly consisting of the Medical Director, Pharmacist, Nurse Manager, and Administrator. The committee shall be responsible for the following:
 - 1) Serve as an advisory group to the medical staff;
 - 2) Approve the policies and procedures for pharmaceutical service annually;
 - 3) Approve medication formulary annually;
 - 4) Approve floor stock annually; and
 - 5) Discuss medication errors and adverse drug reactions.

~~(2).~~ Orders for Medications

- ~~(i)a)~~ A physician must order all medications for the patient. All medications shall be ordered by the physician or credentialed licensed practitioner according to their scope of practice if approved by the Medical Staff and Governing Body.
- ~~(i)b)~~ If the medication order is verbal:
 - ~~(a1)~~ The physician ~~must~~ shall give the order ~~it~~ only to a licensed nurse, pharmacist, or another physician; and

~~(b2)~~ The individual receiving the order ~~must~~ shall record and sign it immediately. ~~and have the~~ The prescribing physician shall sign it in a manner consistent with good medical practice in the time frame determined by hospice policy.

~~(3)~~ Administration of Medication

Medications ~~are~~ shall be administered only by one of the following individuals:

~~(i)~~ A licensed nurse or physician. Licensed personnel in accordance with their scope of practice; and

~~(ii)~~ The patient if his or her attending physician has approved with approval of the attending physician and according to hospice policy.

~~(4)~~ Control and Accountability

The pharmaceutical service has procedures for control and accountability of all drugs and biologicals throughout the facility. Drugs are dispensed in compliance with Federal and State laws. Records of receipt and disposition of all controlled drugs are maintained in sufficient detail to enable an accurate reconciliation. The pharmacist determines ~~that~~ drug records are in order and ~~that~~ an account of all controlled drugs is maintained and reconciled.

~~(5)~~ Labeling of Drugs and Biologicals

The labeling of drugs and biologicals is based on currently accepted professional principles and includes the appropriate accessory and cautionary instructions, as well as the expiration date when applicable.

~~(6)~~ Storage

In accordance with State and Federal laws, all drugs and biologicals are ~~stored in~~ locked compartments and stored under proper temperature controls and only authorized personnel shall have access to the keys. ~~Separately locked compartments are provided for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention & Control Act of 1970 and other drugs subject to abuse, except under single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.~~ An emergency medication kit approved by the Pharmaceutical Services Committee is kept readily available. Scheduled drugs shall be maintained as required by Federal and State regulations.

~~(7)~~ Drug Disposal

Controlled substances no longer ~~needed~~ required by a patient residing in an inpatient hospice shall be disposed of ~~in compliance with State requirements.~~ In the absence of State requirements, the pharmacist and a registered nurse dispose of the drugs and prepare a record of disposal by returning unused medications and a Report of Drugs Surrendered Form to Pharmacy Services and Drug Control, Arkansas Department of Health

E. Linen.

The hospice has available at all times a quantity of linen essential for proper care and comfort of patients. Linens are handled, stored, processed, and transported in such a manner as to prevent the spread of infection

F. Pet Therapy

Birds, cats, dogs, and other animals may be permitted to visit in the patient's room and shall not negatively affect the well being of the patient. Animals shall have appropriate vaccinations and licenses. A veterinary record shall be kept on all therapy animals to verify vaccinations and be made readily available for review. Therapy pets shall not be allowed in food preparation, food storage, dining or service areas.

SECTION 23: INFECTION CONTROL

- A. There shall be a comprehensive list of communicable diseases for which patients shall be isolated and for which there are visitation restrictions. The list, and other policies and procedures for isolation, shall conform to the latest edition of the Centers for Disease Control and Prevention, (CDC) Guidelines.
- B. Isolation procedures and requirements shall conform to the most current CDC Guidelines.
- C. Techniques for:
1. Sterilization;
 2. Sanitary food preparation;
 3. Housekeeping
 4. Linen Care;
 5. Separation of clean from dirty process; and
- D. Use of disinfectants, antiseptics and germicides according to the manufacturer's directions.

SECTION 24: CONSTRUCTION REGULATIONS AND CODES PHYSICAL ENVIRONMENT.

~~Free standing hospice shall meet the applicable construction requirements of the Rules and Regulations for Hospitals and Related Institutions in Arkansas. Act 414 of 1961 as amended.~~

A. A homelike setting design and functional program shall include the following:

1. A place where all family members, including children, may come and go in a natural, family-like manner;
2. Social areas where family members may bring food and dine together and enjoy music, games, and other activities common to the family unit; and
3. A balance between privacy and opportunity for social interaction.
4. Patients Areas: Bedrooms, dining areas, lounges, and surroundings shall be designed to promote privacy and dignity for the patient and family. The interior design of patient use areas shall consider lighting, the use of finish materials, furniture arrangement, and equipment to create a home like ambience without compromising the ability of caregivers to attend to the needs of the patient. Patient toilet rooms shall be accessible and provide adequate space for staff assistance in wheelchair transfers as necessary for at least 50% of patient capacity.

B. Building and Grounds.

1. The building and equipment shall be maintained in a state of good repair at all times.
2. Facilities and their premises shall be kept clean, neat and free of litter, rubbish. ~~The facility shall have written policies and procedures for housekeeping.~~
3. Rooms for gas fired equipment shall not be used for storage except for noncombustible materials.
4. Portable equipment shall be supervised by the department having control of such equipment and shall be stored in areas which are not accessible to patients, visitors, or untrained personnel.
5. Corridors, attics, and passageways shall be free of storage. Exits shall not be blocked by storage of furniture or equipment at any time.

6. Each hospice shall develop a written preventive maintenance plan including all electrically powered patient care equipment, physical plant equipment and fire alarms and detection systems. This plan shall be available to the Department for review at any time. Such plans shall provide for maintenance as recommended by manufacturer, applicable codes, or designer and ensure that equipment and systems perform properly and safely.
7. The handwashing stations in visitors' rest rooms and the handwashing stations used by staff personnel shall be equipped with a soap dispenser, and a towel dispenser.
8. A supply of hot water for patient use shall be available at all times. A weekly hot water temperature log shall be maintained.
9. Heating, ventilating and air-conditioning (HVAC) systems shall be operated, and maintained in a manner to provide a comfortable and safe environment for patients, personnel, and visitors. An air filter change out log shall be maintained.

10. Steam and Hot Water Systems and Pressure Vessels.

All pressure vessels shall meet the requirements of the Arkansas Boiler Inspector, Arkansas Department of Labor. Boiler feed pumps, heating circulating pumps, condensate return pumps, and fuel oil pumps shall be connected and installed to provide normal and standby service.

C. Maintenance and Engineering.

Emergency Procedures Program (EPP). There shall be written emergency procedures or a disaster management plan for utility system disruptions or failures which address the specific and concise procedures to follow in the event of a utility system malfunction or failure of the water supply, hot water system, medical gas system, sewer system, bulk waste disposal system, natural gas system, commercial power system, communication system, boiler or steam delivery system. These procedures shall be kept separate from all other policy and procedure manuals as to facilitate their rapid implementation. These procedures shall contain but are not limited to the following information:

1. A method of obtaining alternative sources of essential utilities;
2. A method of shutoff and location of valves for malfunctioning systems;
3. A method of notification of hospice staff in affected areas;

4. A method of obtaining repair services.

D. Environmental Services.

Solutions, cleaning compounds, disinfectants, vermin control chemicals, and all other potentially hazardous substances that are used in connection with environmental services shall be:

1. Kept in containers which accurately reflect at least the following:
 - a. Content name;
 - b. Concentration of solution;
 - c. Expiration date and lot number;
2. Stored in a secured area. Under no circumstances shall these substances be stored in or near food storage or food preparation areas;

E. Laundry Services.

1. Facility laundry service:
 - a. Sorting of soiled laundry shall be done in a designated area;
 - b. Tables or bins shall be provided for sorting of soiled laundry;
 - c. Lint traps shall be provided on dryers and shall be cleaned regularly;
 - d. Prerinsing shall be done in the laundry service not in showers, bathtubs or lavatories;
 - e. Removal of solid soil shall be done in soiled utility rooms or rooms that are designated for this purpose;
 - f. Patient clothing may be washed in the patient area if a separate equipped laundry room is available;
 - g. A rinsing sink shall be provided in the soiled linen area of the laundry;
 - h. Hot water supplied to laundry areas shall be for plain water nothing under 120°F. Chlorine bleach, if used, shall be used at 150 parts per million. Provisions shall be made to provide 160°F hot water at

the laundry equipment when needed. (This may be a steam jet or separate booster heater.) However, this does not imply that all water used would be at this temperature. Water temperatures required for acceptable laundry results will vary. Lower temperatures may be adequate for most procedures in many facilities but the higher 160°F should be available when needed for special conditions;

- i. Linen contained in hot water soluble plastic bags (identified as being contaminated) shall be placed directly into the washing machine without being removed from the bag for sorting;
- j. A lavatory equipped with wrist action controls, a soap dispenser and a towel dispenser shall be provided in the laundry for use by the personnel;

2. Facilities which do not have laundry services on site:

- a. The facility shall designate a person to determine that all launderable items processed in a commercial laundry shall be in accordance with standards set forth in this section;
- b. Soiled, wet, and contaminated laundry shall be stored in a designated area until pick up by the commercial laundry;
- c. A designated clean area shall be provided for receiving clean laundry and shall be separate from the soiled laundry area;
- d. Clean linen shall be packaged and protected from contamination during transportation and storage.

F. Safety.

- 1. There shall be an effective program to enhance safety within the facility and grounds
- 2. Any fire or disaster event at the facility shall be reported immediately to the Arkansas Department of Health by telephone 501-661-2201 during regular working hours or to 1-800-554-5738 or 501-661-2136 after normal working hours, holidays and weekends.

3. Facilities that permit smoking in the building shall post “No Smoking” signs in any room or compartment where flammable liquids, combustible gases, or oxygen is used or stored, and in any other hazardous locations. Smoking shall be prohibited by patients classified as not responsible, except when the patient is under the direct supervision of the staff.
4. There shall be keys available to assure prompt access to all locked areas. All doors shall be devised so they can be opened from the inside of the locked area. Special door locking devices are acceptable in limited areas. Usage is subject to all codes and regulations.
5. All required exit doors shall remain unlocked per NFPA requirements.

SECTION 25: PHYSICAL FACILITIES

A. General Considerations.

- 1. The requirements set forth herein have been established by the Department and constitute minimum requirements for the design, construction, renovation, and repair of facilities requiring licensure under these regulations.**
- 2. Facilities shall be accessible to the public, staff, and patients with physical disabilities.**
- 3. Projects involving existing facilities shall be programmed and phased to minimize disruption of the existing functions. Access, exits and fire protection shall be maintained for the occupant's and the facility's safety.**
- 4. Codes and Standards. Nothing stated herein shall relieve the owner from compliance with building codes, ordinances, and regulations which are enforced by city, county, or other State jurisdictions. Where such codes, ordinances, and regulations are not in effect, the owner shall consult the state building codes for all components of the building type which are not specifically covered by these minimum requirements. In location where there is a history of tornadoes, floods, earthquakes or other regional disasters, planning and design shall consider the need to protect the occupants and the facility.**

B. Occupancy: Each licensed facility or portion of a licensed facility shall be classified as indicated below:

In-patient Direct Care Hospice: In-patient Direct Care Hospice means a licensed hospice facility that provides direct in-patient care to the terminally ill.

C. Multiple Occupancy: Facilities may contain more than one provided each different occupancy is separated from all other occupancies by a 2-hour fire resistive rated smoke barrier.

D. Construction Projects: Each construction project shall be classified as indicated below:

- 1. Addition: A project that increases the floor area of a licensed facility.**
- 2. Repair: A project that provides for the repair or renewal of a licensed facility or portion of a licensed facility solely for the purpose of its maintenance.**

3. Simple Renovation: A project other than repair that meets all of the criteria listed below:

- a. The project does not increase the floor area of a licensed facility.
- b. The project does not change the occupancy of a licensed facility or portion of a licensed facility.
- c. The project does not involve more than two (2) smoke compartments.
- d. The smoke compartments affected by the project were completely protected by an automatic sprinkler system prior to the project or the project provides for the installation of a complete automatic sprinkler system in all smoke compartments that are affected by the project.

4. Complex Renovation: A project other than Addition, Repair, or Simple Renovation.

E. Applicable Requirements Based upon Occupancy:

Existing Facilities: Existing facilities that do not comply with these regulations shall be permitted to continued in service, provided the lack of conformity with these regulations does not present a serious hazard to the occupants as determined by Health Facility Services or other authorities having jurisdiction.

F. Applicable Requirements Based upon the Type of Project:

1. General:

- a. Where renovation work is done within an existing facility, all new work, or additions, or both, shall comply, insofar as practical with applicable sections of these regulations and appropriate sections of National Fire Protection Association (NFPA) 101 Life Safety Code covering new occupancies.
- b. In renovation projects and projects involving additions to existing facilities, only that portion of the total facility affected by the project shall comply with applicable sections of these regulations and with appropriate parts of NFPA 101 covering new occupancies. Existing portions of the facility that are not included in the project but essential to the functioning of a complete facility shall comply (at a minimum) with the appropriate sections of NFPA 101 covering existing occupancies. Existing portions of the facility that receive less then substantial amounts of new work, shall also comply (at a

minimum) with the appropriate sections of NFPA 101 covering existing occupancies.

c. Facilities or portions of facilities shall be permitted to be occupied during construction, renovation, and repair only where required means of egress and required fire protection features are in place and continuously maintained for the portion occupied or where alternate life safety measures acceptable to the Division and other authorities having jurisdiction are in place.

2. Addition, Simple Renovation, and Complex Renovation shall be designed, constructed, and renovated in accordance with the applicable Sections of these regulations and all Appendices and publications referenced by these Sections.

3. Repair projects shall be designed and constructed in a manner that does not diminish the safety level that existed prior to the start of the work.

G. Project Review and Approval Process.

1. Coordination: Health Facilities Services will coordinate the review and approval process for all offices of the Department.

2. Addition, Simple or Complex Renovation Projects shall be reviewed and approved by the Division as indicated below:

a. Drawing Review and Approval Process:

1) Submission of Plan Review Fee: A plan review fee in the amount of one percent of the total cost of construction or \$500.00, whichever is less, shall be paid for the review of plans and specifications. The plan review fee check is to be made payable to the Arkansas Department of Health. A detailed estimate shall accompany the plans unless the maximum fee of \$500.00 is paid.

2) Submission of Functional Program and Cost Estimate.

3) Submission of Site Location.

4) Submission of Preliminary Plans.

5) Review of functional program, site location, and preliminary plans: Health Facility Services shall review the functional program, site location, and preliminary plans and forward a written response with comments to the Facility.

6) Submission of Final Construction Documents.

7) Review and Approval of Final Construction Documents: Health Facility Services shall review the final construction documents and forward a written response with comments to the Facility. Health Facility Services shall have a minimum of six (6) weeks to review final construction Documents. The written response shall indicate whether or not the final construction documents are approved. If the final construction documents are not approved, the written response shall indicate the design modifications required to secure approval.

b. Approval to Begin Construction: Facilities may proceed with addition and complex renovation projects after receiving a letter from Health Facility Services stating that the final construction documents have been reviewed and approved and after receiving approval from other authorities having jurisdiction.

c. Site Inspections During Construction.

d. Final Site Inspection.

3. Repair: Repair projects do not require Health Facility Services review and approval.

H. Site Location.

1. Roads and Parking.

a. Paved roads and walks shall be provided within the lot lines to provide access to the main entrance and service entrance, including loading and unloading docks for delivery trucks. Paved walkway shall be provided for necessary pedestrian traffic.

b. Each facility shall have parking spaces to satisfy the minimum needs of patients, employees, staff, and visitors. In the absence of a formal parking study, each facility shall provide not less than one space for each day shift staff member and employee plus one space for each patient bed. This ratio may be reduced in an area convenient to a public transportation system or to a public parking facility if proper justification is given and provided that approval of any reduction is obtained from the Department.

2. Subsoil Investigation. Subsoil investigation shall be made to determine the subsurface soil and water conditions. The investigation shall include a sufficient number of test pits or test borings to determine, in the judgment of the architect and the structural engineer, the true subsurface conditions. Results of the investigation shall be available in the form of a soil investigation report or a foundation engineering report. The investigation shall be made in close cooperation with the architect and structural engineer and shall contain detailed recommendations for foundation design and gradings.
 3. Approval. The new building site shall be inspected and approved by the Department before construction begins.
- I. Preliminary Plans: Preliminary plans submitted to the Division shall include as a minimum the following information:
1. Floor plans drawn to scale that indicate room names, room dimensions, corridor dimensions, locations of fire resistive rated partitions, and locations of rated smoke barriers.
 2. An existing floor plan indicating existing spaces and exits and their relationship to the new construction (renovation projects only).
 3. Building sections that establish the proposed construction type and fire rating. Sections shall be drawn at a scale sufficiently large to clearly present the proposed construction system.
 4. A site plan that indicates the location of proposed roads, walks, service and entrance courts, parking, and orientation.
 5. Simple horizontal and vertical space diagrams that indicate the relationship of various departments and services to each other the general room arrangement in each department.
 6. A narrative description of proposed mechanical, electrical, and fire protection systems.
- J. Final Construction Documents.
1. Construction Documents shall be prepared by an architect and/or professional engineer licensed by the State of Arkansas. .
 2. Architectural construction documents shall be prepared by an architect and engineering construction documents (structural, mechanical, electrical, and civil) shall be prepared by a qualified engineer. The documents shall be stamped with appropriate seals for each discipline.

3. Periodic observations of construction shall be provided and documented by each design professional. Design professionals shall verify that the construction is in accordance with the construction documents and that the Record Drawings are properly maintained.
 4. The construction contract shall contain a provision to withhold progress payments to the contractor until the Record Drawings are current.
 5. Final Construction Documents shall include drawings and specifications. Separate drawings and specifications shall be prepared for each of the following branches of work: architectural, structural, mechanical, electrical, life safety and fire protection.
 - a. Specifications: Specifications shall supplement the drawings to fully describe types, sizes, capacities, workmanships, finishes, and other characteristics of all materials and equipment and shall include the following:
 - 1) Cover or title sheet with architectural seal;
 - 2) Index;
 - 3) General conditions;
 - 4) General requirements;
 - 5) Sections describing material and workmanship in detail for each class of work.
 - b. All construction documents and specifications shall be approved by the Department prior to the beginning of construction and a letter shall be issued from the licensing agency granting approval to commence with construction. The Department shall have a minimum of six (6) weeks to review construction documents and specifications. Health Facility Services shall coordinate the plan review with other Divisions in the Department. Penalties for starting construction without Department approval see Section 4.I, Licensure and Codes.
- K. Site Inspection During Construction. The Department shall inspect the project during the construction process as indicated below:
1. This Department is to be notified when construction begins and a construction schedule shall be submitted to determine inspection dates.

2. Representatives from the Department shall have access to the construction premises and the construction project for purposes of making whatever inspections deemed necessary throughout the course of construction.
3. Any deviation from the accepted construction documents shall not be permitted during construction, until the written request for change(s) in the construction is approved by this Department.

L. Final Site Inspection.

1. Upon completion of construction and prior to the approval by the Department to occupy and use the facility, the owner shall be furnished a complete set of record drawings and a complete set of installation, operation, and maintenance manuals and parts lists for the installed equipment.
2. A list of final site inspection items has been provided in the Table 5 of the Appendix.
3. No facility shall occupy any new structure or major addition or renovation space until the appropriate permission has been received from the local building and fire authorities and licensing agency.

SECTION 26: PHYSICAL FACILITIES, PATIENT ACCOMMODATIONS FOR HOSPICE FACILITIES

A. Patient Rooms. Each patient room shall meet the following requirements.

1. Maximum room capacity shall be two patients.
2. In new construction, patient rooms shall have a minimum of 100 square feet of clear floor area per bed in semi-private rooms and 120 square feet of clear floor area for single-bed rooms, exclusive of toilet rooms, closets, lockers, wardrobes, alcoves or vestibules. The dimensions and arrangement of rooms shall be such that there is a minimum of three feet between the sides and foot of the bed and any wall, other fixed obstruction, or another bed. In semi-private bed rooms, a clearance of four feet shall be available at the foot of each bed to permit the passage of equipment and beds.

Minor encroachments, including columns and lavatories, that do not interfere with functions may be ignored when determining space requirements for patient rooms. Where renovation work is undertaken, every effort shall be made to meet the above minimum standards.

3. Each patient room shall have a window with outside exposure and where the operation of windows or vents requires the use of tools or keys, such devices shall be on the same floor and easily accessible to staff. The windowsills shall not be higher than three feet above the floor and shall be above the grade. Patient rooms in new construction intended for 24 hour occupancy shall have windows. If operable windows are installed, such devices shall be restricted to inhibit possible escape or suicide.
4. Each patient shall have access to a toilet room without having to enter the general corridor area. One toilet room shall serve no more than four patient beds and no more than two patient rooms. In new construction, an additional handwashing station or sanitizing station shall be placed in the patient room where the toilet room serves more than one bed. The toilet room shall contain a water closet and a handwashing station and the door shall swing outward or be double acting.
5. Each patient shall have within the room a separate wardrobe or closet that is suitable for hanging full length garments and for storing personal items.
6. Visual privacy from casual observation by other patients and visitors shall be provided for each patient in semi-private rooms with cubicle curtains or equivalent built-in or movable dividers. The method for providing privacy shall not obstruct passage of other patients either to the entrance, toilet, or

lavatory. All curtains shall have a flame spread of 0 to 25 and shall comply with NFPA 13 requirements for clear space below sprinklers.

7. Each room shall connect directly with a corridor without passage through another patient's room.
8. Rooms existing partially below grade level shall not be used for patients unless they are dry, well ventilated, and are otherwise suitable for occupancy.
9. Beds shall be arranged to provide adequate room for all patient care procedures and to prevent the transmission of infections.
10. Suitable beds shall be provided. Bed rails shall be provided on beds for children.
11. A reading light shall be provided for each patient bed. The location and design shall be such that the light is not annoying to other patients.
12. A bedside table with drawer shall be provided for each bed. The lower portion of the table and/or enclosed shelves shall be provided for individual nursing care equipment.
13. A bathing facility containing either a bathtub or a shower accessible to a wheeled shower chair shall be conveniently accessible to patient rooms. An accessible toilet room shall be accessible to the bathing room.

B. Service Areas. Each services area may be arranged and located to serve more than one nursing unit but at least one such service area shall be provided on each nursing floor. Some of the service areas may be combined in a single space. The following service areas shall be located in or readily available to each nursing unit:

1. Nursing Station. Facilities for charting, clinical records, work counter, communication system, space for supplies and convenient access to handwashing stations shall be provided. It may be combined with or include centers for reception and communication;
2. Dictation area shall be provided. This area shall be adjacent to but separate from the nurses' station;
3. Toilet room(s) for staff convenient to nurses' station (may be unisex);
4. Multi-purpose room(s) for staff, patients, patients' families for patient conferences, reports, education, training sessions, and consultation

5. Clean workroom or clean supply room. If the room is used for preparing patient care items, it shall contain a work counter, a handwashing fixture, and storage facilities for clean and sterile supplies. If the room is used only for storage and holding as part of a system for distribution of clean and sterile materials, the work counter and handwashing fixture may be omitted. Soiled and clean workrooms or holding rooms shall be separated and have no direct connection;
6. Soiled workroom or soiled holding room. This room shall be separate from the clean workroom. The soiled workroom shall contain a clinical sink (or equivalent flushing-rim fixture). The room shall contain a lavatory (or handwashing fixture). The above fixtures shall both have a hot and cold mixing faucet. The room shall have a work counter and space for separate covered containers for soiled linen and waste. Rooms used only for temporary holding of soiled material may omit the clinical sink and work counter. If the flushing-rim clinical sink is eliminated, facilities for cleaning bedpans shall be provided elsewhere;
7. Medication Station. Provisions shall be made for distribution of medications. This may be done from a medicine preparation room or unit, from a self-contained medicine dispensing unit, or by another approved system;
 - a. Medicine preparation room. This room shall be designed to allow for visual supervision by the nursing staff. It shall contain a work counter, a sink adequate for handwashing, refrigerator, and locked storage for controlled drugs. When a medicine preparation room is to be used to store one or more self-contained medicine dispensing units, the room shall be designed with adequate space to prepare medicines with the self-contained medicine dispensing unit(s) present.
 - b. Self-contained medicine dispensing unit. A self-contained medicine dispensing unit may be located at the nurses' station, in the clean workroom, or in an alcove, provided the unit has adequate security for controlled drugs and adequate lighting to easily identify drugs. Convenient access to handwashing stations shall be provided. (Standard cup-sinks provided in many self-contained units are not adequate for handwashing.)
8. Nourishment Station. This shall contain a sink equipped for handwashing, equipment for serving nourishment between scheduled and unscheduled meals, refrigerator, storage cabinets, and ice maker units to provide ice for patients' service and treatment. Ice for human consumption shall be from

self-dispensing units. Handwashing stations shall be in or immediately accessible to the nourishment station;

9. Equipment Storage Room. This shall be for equipment such as I.V. stands, inhalators, air mattresses, walkers and wheelchairs; and

10. A comfortable and easily accessible sleep area for family members.

C. A common kitchen area if provided shall contain a refrigerator, sink and microwave.

D. Dining and/or gathering space for patients and families shall be provided as required by the narrative program.

E. Airborne Infection Isolation Room(s). Rooms for patients who are suffering from infections shall be provided at the rate of one for each 36 beds or fraction thereof.

SECTION 27: PHYSICAL FACILITIES, PHARMACY

The size and type of services to be provided in the pharmacy can largely depend upon the type of medication distribution system used, number of patients to be served, and extent of shared or purchased services. This shall be described in the narrative functional program. The pharmacy room or suite shall be located for convenient access, staff control, and security. Facilities and equipment shall be as necessary to accommodate the functions of the program. See Section 16, Pharmacy, for additional requirements. As a minimum, the following elements shall be included:

A. Dispensing.

1. A pickup and receiving area.
2. An area for reviewing and recording.
3. An extemporaneous compounding area that includes a sink and sufficient counter space for medication preparation.
4. Work counters and space for automated and manual dispensing activities.
5. An area for temporary storage, exchange, and restocking of carts.
6. Security provisions for medications and personnel in the dispensing counter area.

B. Manufacturing.

1. A bulk compounding area.
2. Provisions for packaging and labeling.
3. A quality control area.

C. Storage (may be cabinets, shelves, and/or separate rooms or closets).

1. Bulk storage.
2. Active storage.
3. Refrigerated storage.
4. Volatile fluids and alcohol storage constructed according to applicable fire safety codes for the substances involved.

5. Double-locked storage for controlled substances.

6. Storage for general supplies and equipment not in use.

D. Administration.

1. An area for education and training (may be in a multipurpose room shared with other departments).

2. A separate area for office functions.

E. Other.

1. Handwashing facilities stations shall be provided within each separate room where open medication is handled and readily accessible.

2. Provide for convenient access to toilet and locker.

3. If unit dose procedure is used, provide additional space and equipment for supplies, packaging, labeling, and storage, as well as for the carts.

4. If IV solutions are prepared in the pharmacy, provide a sterile work area with a laminar-flow work station designed for product protection. The laminar-flow system shall include a nonhydroscopic filter (HEPA) rated at 99.97 percent, as tested by DOP tests and have a visible pressure gauge for detection of filter leaks or defects.

5. Hoods used for chemotherapy shall be 100 percent exhausted to the exterior.

6. As a minimum the partitions enclosing the pharmacy shall extend from the floor to the deck above, with gypsum board on both sides of metal studs.

SECTION 28: PHYSICAL FACILITIES, WASTE PROCESSING SERVICES

- A. Hazardous Waste and Antineoplastic Agent Disposal. The facility shall have policies and procedures for the identification, segregation, labeling, storage, transport and disposal of hazardous waste. The policies and procedures shall conform with the latest edition of Hazardous Waste Management Regulation 23, Arkansas Department of Environmental Quality, Little Rock, Arkansas. Within the facility, hazardous waste, especially antineoplastic agents, shall be labeled in a manner that it shall be easily recognized from all other waste. The facility shall compile a list of all antineoplastic agents used in the facility. The facility shall have policies and procedures for the clean up of spills, decontamination and treatment of personnel exposed to hazardous waste and antineoplastic agents.
- B. Regulated Medical Waste (Infectious Waste) Disposal. The facility shall have policies and procedures for the identification, segregation, labeling, storage, transport and disposal of regulated medical waste. All policies and procedures shall conform to the latest edition of the Rules and Regulations Pertaining to the Management of Medical Waste from Generators and Health Care Related Facilities, Arkansas Department of Health, Little Rock, Arkansas. The facility shall have policies and procedures for the clean up of spills, and for decontamination and treatment of personnel exposed to regulated medical waste.
- C. Solid Waste Disposal (Non-Infectious Waste). The facility shall have policies and procedures for the identification, segregation, labeling, storage, transport and disposal of solid waste. Policies and procedures shall conform with the latest edition of the Solid Waste Management Regulation 22, Arkansas Department of Environmental Quality, Little Rock, Arkansas.
- D. Other Waste. The facility shall have policies and procedures for the identification, segregation, labeling, storage, transport, and disposal of any waste not specifically mentioned in this section.

SECTION 29: PHYSICAL FACILITIES, DETAILS AND FINISHES

All details for alteration or expansion projects as well as for new construction shall comply with the following.

A. Details.

1. Compartmentation, exits, automatic extinguishing systems, and other details relating to fire prevention and fire protection shall comply with requirements listed in the NFPA referenced codes, shall be maintained at the facility and shown on the Fire Protection Plan.
2. Corridor partitions, smokestop partitions, horizontal exit partitions, exit enclosures, and fire rated walls required to have protected openings shall be effectively and permanently identified with signs or stenciling in a manner acceptable to the Health Facility Services. Such identification shall be above any decorative ceiling and in concealed spaces.
3. Rooms containing bathtubs, sitz baths, showers, and water closets, subject to occupancy by patients, shall be equipped with doors and hardware which shall permit access from the outside the room.
4. Glass doors, lights, sidelights, borrowed lights, and windows located within 12 inches of a door jamb (with a bottom frame height of less than 60 inches above the finished floor) shall be constructed of safety glass, wired glass, or plastic, break resistant material that creates no dangerous cutting edges when broken. Safety glass-tempered or plastic glazing materials shall be used for shower doors and bath enclosures. In renovation projects, only glazing within 18 inches of the floor shall be changed to safety glass, wire glass, or plastic, break-resistant material.
5. Thresholds and expansion joint covers shall be installed flush with the floor surface to facilitate use of wheelchairs and carts. Expansion and seismic joints shall be constructed to restrict the passage of smoke.
6. Grab bars shall be provided in all patients' toilets, showers, tubs, and sitz baths. The bars shall have one and one-half inch clearance to walls and shall have sufficient strength and anchorage to sustain a concentrated load of 250 pounds.
7. Lavatories and handwashing stations shall be securely anchored to withstand an applied downward vertical load of not less than 250 pounds on the front of the fixture.

8. The minimum ceiling height shall be seven feet ten inches with the following exceptions:
 - a. Boiler rooms shall have ceiling clearances not less than two feet six inches above the main boiler header and connecting piping.
 - b. Ceilings in corridors, storage rooms, and toilet rooms shall be not less than seven feet eight inches in height. Ceiling heights in small, normally unoccupied spaces may be reduced.
 - c. Where existing structures make the above ceiling clearance impractical, clearances shall be as required to avoid injury to individuals up to six feet four inches tall.
9. Rooms containing heat-producing equipment (such as boiler or heater rooms and laundries) shall be insulated and ventilated to prevent any floor or partition surface from exceeding a temperature of ten degrees Fahrenheit above ambient room temperature.
10. Noise reduction criteria shown in Table 2 of the Appendix shall apply to partition, floor, and ceiling construction in patient areas. (Careful attention shall be given to penetrations.)
11. Light fixtures shall be provided with protective covers in food preparation, serving areas, and patient care and treatment spaces. Protective light fixture covers are not required in corridors.
12. Handrails shall be provided on both sides of all corridors used by patients.

B. Finishes.

Floors and walls penetrated by pipes, ducts, and conduits shall be tightly sealed to minimize entry of rodents and insects.

SECTION 30: PHYSICAL FACILITIES, CONSTRUCTION, INCLUDING FIRE RESISTIVE REQUIREMENTS

A. Design. Every building and every portion thereof shall be designed and constructed to sustain all dead and live loads in accordance with American Society of Civil Engineers, (ASCE), "Minimum Design Loads for Buildings and Other Structures."

B. Foundations. Foundations shall rest on natural solid bearing if a satisfactory bearing is available at reasonable depths. Proper soil-bearing values shall be established in accordance with recognized standards. If solid bearing is not encountered at practical depths, the structure shall be supported on drive piles or drilled piers designed to support the intended load without detrimental settlement, except that one story buildings may rest on a fill designed by a soils engineer. When engineered fill is used, site preparation and placement of fill shall be performed under the direct full-time supervision of the soils engineer. The soils engineer shall issue a final report on the compacted fill operation and certification of compliance with the job specifications. All footings shall extend to a depth not less than one foot below the estimated maximum frost line.

C. Construction.

1. Construction shall comply with the applicable requirements of NFPA 101, and the Arkansas Fire Protection Code Volumes I and II and Arkansas State Building Services, Minimum Standards and Criteria - Accessibility for the Physically Disabled Standards.

NOTE: NFPA 101 generally covers fire/safety requirements only, whereas most model codes also apply to structural elements. The fire/safety items of NFPA 101 would take precedence over other codes in case of conflict. In the event NFPA 101 does not specifically address a life safety requirement found only in the Arkansas Fire Prevention Code, compliance with the requirement is not mandatory. Appropriate application of each would minimize problems. For example, some model codes require closers on all patient doors. NFPA 101 recognizes the potential fire/safety problems of this requirement and stipulates that if closers are used for patient room doors, smoke detectors shall also be provided within each affected patient room.

2. For renovation projects, the extent of new construction shall be determined by the licensing agency. Construction shall comply with applicable requirements of NFPA 101.

D. Elevators. All facilities located on other than the grade-level entrance floor shall have electric or hydraulic elevators. Elevator cars shall have inside dimensions that accommodate a patient bed with attendants. Cars shall be at least five feet eight inches wide by nine feet deep. Car doors shall have a clear opening of not less than four feet wide and seven feet high. In renovations, existing elevators that can accommodate patient beds used in the facility will not be required to be increased in size.

NOTE: Additional elevators installed for visitors and material handling may be smaller than noted above, within restrictions set by standards for disabled access.

SECTION 31: PHYSICAL FACILITIES, PLUMBING AND OTHER PIPING SYSTEMS

All plumbing systems shall be designed and installed in accordance with the requirements of the latest edition of the Arkansas State Plumbing Code and the latest edition of the Laws, Rules, and Regulations Governing Boiler Inspection, Arkansas Department of Labor.

SECTION 32: PHYSICAL FACILITIES, ELECTRICAL STANDARDS

A. Lighting.

- 1. Approaches to buildings and parking lots, and all occupied spaces within buildings shall have fixtures that can be illuminated as necessary.**
- 2. Patient rooms shall have general lighting and night lighting.**
- 3. Nursing unit corridors shall have general illumination with provisions for reducing light levels at night.**
- 4. Egress and exit lighting shall comply with NFPA 101.**

B. Nurse/Patient Communication Station.

- 1. A nurse/patient communication system shall be provided for each patient bedside as in accordance with the functional program.**
- 2. An emergency call system shall be provided in each patient's toilet, bath and shower room.**

C. Emergency electrical generators shall have a minimum 48 hours of on-site fuel.

D. All health care occupancies shall be provided with a fire alarm system in accordance with NFPA 101 and NFPA 72.

SECTION 33: SEVERABILITY

If any provision of these Rules and Regulations for Hospice in Arkansas or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of the Rules which can be given effect without the invalid provision or application and to this end the provisions of these Rules are declared to be severable.

~~REPEAL~~

~~All Regulations and parts of Regulations in conflict herewith are hereby repealed.~~

RULES AND REGULATIONS FOR HOSPICE IN ARKANSAS
ACT 283 OF 1983

Amendment No. 1

Under DEFINITIONS, Item 15, Terminally Ill to read:

29. Terminally Ill means that the individual is in the last phases of incurable illness and has a limited prognosis.

Amendment No. 2

Under CERTIFICATION OF TERMINAL ILLNESS, Item (b) Certification Statement to read:

(3) Certification Statement. The certification statement must includeB

(1) The statement that the individual has a medical prognosis with a limited life expectancy and for Medicare has a prognosis which is in compliance with the Medicare Hospice Regulations.

Amendment No. 3

Under CERTIFICATION OF TERMINAL ILLNESS, Item (a) Obtaining Statement to read:

(1) Obtaining Statement. If the written certification is not obtained within two (2) calendar days following the initiation of hospice care, a verbal certification may be made within two (2) days following the initiation of hospice care, with a written certification not later than eight (8) days after care is initiated.

|

APPENDIX

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TABLE 1

<u>Filter Efficiencies for Central Ventilation and Air Conditioning Systems in Health Care Facilities</u>			
<u>Area Designation</u>	<u>No. Filter Beds</u>	<u>Filter Bed No.1 (%)</u>	<u>Filter Bed No.2¹ (%)</u>
<u>All areas for patient care, treatment, and diagnosis, and those areas providing direct service or clean supplies such as sterile and clean processing.</u>	<u>2</u>	<u>30</u>	<u>90</u>
<u>Positive Protective Environment Room</u>	<u>2</u>	<u>30</u>	<u>99.97</u>
<u>Laboratories</u>	<u>1</u>	<u>80</u>	<u>=</u>
<u>Administrative, Bulk Storage, Soiled Holding Areas, Food Preparation Areas, and Laundries</u>	<u>1</u>	<u>30</u>	<u>=</u>

¹These requirements do not apply to small outpatient clinics or outpatient clinics that do not perform invasive applications or procedures.

Notes: The filtration efficiency ratings are based on average dust spot efficiency per ASHRAE 52-76.1 – 1992.

Additional roughing or prefilters should be considered to reduce maintenance required for filters with efficiencies higher than 75 percent.

TABLE 2

Sound Transmission Limitations in Health Care Facilities		
	<u>Airborne Sound Transmission Class (STC)¹</u>	
	<u>Partitions</u>	<u>Floors</u>
<u>NEW CONSTRUCTION²</u>		
<u>Patients' Room to Patients' Room</u>	<u>45</u>	<u>40</u>
<u>Public Space to Patients' Room³</u>	<u>55</u>	<u>40</u>
<u>Service Areas to Patients' Room⁴</u>	<u>65</u>	<u>45</u>
<u>Patient room access corridor⁵</u>	<u>45</u>	<u>45</u>
<u>Exam room to exam room</u>	<u>45</u>	<u>---</u>
<u>Exam room to public space</u>	<u>45</u>	<u>---</u>
<u>Toilet room to public space</u>	<u>45</u>	<u>---</u>
<u>Consultation rooms/ conference rooms to public space</u>	<u>45</u>	<u>---</u>
<u>Consultation rooms/ Conference rooms to patient rooms</u>	<u>45</u>	<u>---</u>
<u>Staff lounges to patient rooms</u>	<u>45</u>	<u>---</u>
<u>Existing Construction²</u>		
<u>Patient room to patient room</u>	<u>35</u>	<u>40</u>
<u>Public space to patient room³</u>	<u>40</u>	<u>40</u>
<u>Service areas to patient room⁴</u>	<u>45</u>	<u>45</u>

1. Sound transmission class (STC) shall be determined by tests in accordance with methods set forth in ASTM Standard E90 and ASTM E413. Where partitions do not extend to the structure above, sound transmission through ceilings and composite STC performance shall be considered.
2. Treatment rooms shall be treated the same as patient rooms
3. Public space includes corridors (except patient room access corridors), lobbies, dining rooms, recreation rooms, treatment rooms, and similar spaces.
4. Service areas include kitchens, elevators, elevator machine rooms, laundries, and similar spaces garages, maintenance rooms, boiler and mechanical equipment rooms, and similar spaces of high noise. Mechanical equipment located on the same floor or above patient rooms, offices, nurses stations, and similar occupied space shall be effectively isolated from the floor.
5. Patient room access corridors contain composite walls with doors/windows and have direct access to patient

TABLE 3

<u>Temperature and Relative Humidity Requirements</u>		
<u>Area Designation</u>	<u>Dry Bulb Temperatures °F¹</u>	<u>Relative Humidity (%) Minimum-Maximum²</u>
<u>Sterile Storage</u>	<u>75</u>	<u>70 (max)</u>

¹Note: Where temperature ranges are indicated, the systems shall be capable of maintaining the rooms at any point within the range. A single figure indicates a heating or cooling capacity of at least the indicated temperature. This is usually applicable when patients may be undressed and require a warmer environment. Nothing in these guidelines shall be construed as precluding the use of temperatures lower than those noted when the patients' comfort and medical conditions make lower temperatures desirable. Unoccupied areas such as storage rooms shall have temperatures appropriate for the function intended.

TABLE 4
Ventilation, Medical Gas, and Air Flow Requirements in Health Care Facilities¹

<u>Area Designation</u>	<u>Air Movement Relationship To Adjacent Area²</u>	<u>Minimum Air Changes Outside Air Per Hour³</u>	<u>Minimum Total Air Changes Per Hour^{4,5}</u>	<u>Air Recirculated By Means of Room Units⁷</u>	<u>All Air Exhausted Directly Outdoor⁶</u>
<u>NURSING AREAS</u>					
<u>Patient Room</u>	-	2	6 ⁹	Optional	Optional
<u>Toilet Room</u>	In	-	10	Optional	Yes
<u>Newborn Nursery Suite</u>	-	2	6	No	Optional
<u>Protective environment room^{8, 10}</u>	Out	2	12	No	Optional
<u>Airborne Infectious Isolation, Bronchoscopy Room^{8, 11}</u>	In	2	12	No	Yes
<u>Isolation alcove or anteroom^{10, 11}</u>	In/Out	-	10	No	Yes
<u>Labor/Delivery/Recovery (LDR)</u>	-	2	6 ⁹	Optional	Optional
<u>Labor/Delivery/ Recovery/ Post Partum (LDRP)</u>	-	2	6 ⁹	Optional	Optional
<u>Patient Corridor</u>	-	-	2	Optional	Optional
<u>ANCILLARY AREAS</u>					
<u>Pharmacy</u>	Out	-	4	Optional	Optional
<u>DIAGNOSTIC AND TREATMENT AREAS</u>					
<u>Examination Room</u>	-	-	6	Optional	Optional
<u>Medication Room</u>	Out	-	4	Optional	Optional
<u>Treatment Room</u>	-	-	6	Optional	Optional
<u>Physical Therapy and Hydrotherapy</u>	In	-	6	Optional	Optional
<u>Soiled Workroom or Soiled Holding</u>	In	-	10	No	Yes
<u>Clean Workroom or Clean Holding</u>	Out	-	4	Optional	Optional
<u>SERVICE AREAS</u>					
<u>Food Preparation Centers¹²</u>	-	-	10	No	Optional
<u>Warewashing</u>	In	-	10	No	Yes
<u>Dietary Day Storage</u>	In	-	2	Optional	Optional
<u>Laundry, General</u>	-	-	10	Optional	Yes
<u>Soiled Linen Sorting and Storage</u>	In	-	10	No	Yes
<u>Clean Linen Storage</u>	Out	-	2	Optional	Optional
<u>Soiled Linen and Trash Chute Room</u>	In	-	10	No	Yes
<u>Bedpan Room</u>	In	-	10	Optional	Yes
<u>Bathroom</u>	In	-	10	Optional	Optional
<u>Janitor's closet</u>	In	-	10	No	Yes

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Notes for Table 4

1. The ventilation rates in this table cover ventilation for comfort, as well as for asepsis and odor control in areas of acute care hospitals that directly affect patient care and are determined based on healthcare facilities being predominantly "No Smoking" facilities. Where smoking may be allowed, ventilation rates will need adjustment. Areas where specific ventilation rates are not given in the table shall be ventilated in accordance with ASHRAE Standard 62, Ventilation for Acceptable Indoor Air Quality; and ASHRAE Handbook-HVAC Applications. Specialized patient care areas, including organ transplant units, burn units, specialty procedure rooms, etc., shall have additional ventilation provisions for air quality control as may be appropriate. OSHA standards and/or NIOSH criteria require special ventilation requirements for employee health and safety within healthcare facilities.
2. Design of the ventilation system shall provide air movement which is generally from clean to less clean areas. If any form of variable air volume or load shedding system is used for energy conservation, it shall not compromise the corridor-to-room pressure balancing relationships or the minimum air changes required by the table.
3. To satisfy exhaust needs, replacement air from the outside is necessary. Table 4 does not attempt to describe specific amounts of outside air to be supplied to individual spaces except for certain areas such as those listed. Distribution of the outside air, added to the system to balance required exhaust, shall be as required by good engineering practice. Minimum outside air quantities shall remain constant while the system is in operation.
4. Number of air changes may be reduced when the room is unoccupied if provisions are made to ensure that the number of air changes indicated is reestablished any time the space is being utilized. Adjustments shall include provisions so that the direction of air movement shall remain the same when the number of air changes is reduced. Areas not indicated as having continuous directional control may have ventilation systems shut down when space is unoccupied and ventilation is not otherwise needed, if the maximum infiltration or exfiltration permitted in Note 2 is not exceeded and if adjacent pressure balancing relationships are not compromised. Air quantity calculations shall account for filter loading such that the indicated air change rates are provided up until the time of filter change-out.
5. Air change requirements indicated are minimum values. Higher values should be used when required to maintain indicated room conditions (temperature and humidity), based on the cooling load of the space (lights, equipment, people, exterior walls and windows, etc.).
6. Air from areas with contamination and/or odor problems shall be exhausted to the outside and not recirculated to other areas. Note that individual circumstances may require special consideration for air exhaust to the outside, e.g., in intensive care units in which patients with pulmonary infection are treated, and rooms for burn patients.
7. Recirculating room HVAC units refers to those local units that are used primarily for heating and cooling of air, and not disinfection of air. Because of cleaning difficulty and potential for buildup of contamination, recirculating room units shall not be used in areas marked "No." However, for airborne infection control, air may be recirculated within individual isolation rooms if HEPA filters are used. Isolation and intensive care unit rooms may be ventilated by reheat induction units in which only the primary air supplied from a central system passes through the reheat unit. Gravity-type heating or cooling units such as radiators or convectors shall not be used in operating rooms and other special care areas. See Appendix A for a description of recirculation units to be used in isolation rooms.
8. Differential pressure shall be a minimum of 0.01" water gauge (2.5 Pa). If alarms are installed, allowances shall be made to prevent nuisance alarms of monitoring devices.
9. Total air changes per room for patient rooms, labor/delivery/recovery rooms, and labor/delivery/recovery/postpartum rooms may be reduced to 4 when supplemental heating and/or cooling systems (radiant heating and cooling, baseboard heating, etc.) are used.
10. The protective environment airflow design specifications protect the patient from common environmental

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airborne infectious microbes (i.e., Aspergillus spores). These special ventilation areas shall be designed to provide directed airflow from the cleanest patient care area to less clean areas. These rooms shall be protected with HEPA filters at 99.97 percent efficiency for a 0.3 micron sized particle in the supply airstream. These Interrupting filters protect patient rooms from maintenance-derived release of environmental microbes from the ventilation system components. Recirculation HEPA filters can be used to increase the equivalent room air exchanges. Constant volume airflow is required for consistent ventilation for the protected environment. If the facility determines that airborne infection isolation is necessary for protective environment patients, an anteroom shall be provided. Rooms with reversible airflow provisions for the purpose of switching between protective environment and airborne infection isolation functions are not acceptable.

11. The infectious disease isolation room described in these guidelines is to be used for isolating the airborne spread of infectious diseases, such as measles, varicella, or tuberculosis. The design of airborne infection isolation (All) rooms should include the provision for normal patient care during periods not requiring Isolation precautions. Supplemental recirculating devices may be used in the patient room, to increase the equivalent room air exchanges; however, such recirculating devices do not provide the outside air requirements. Air may be recirculated within individual isolation rooms if HEPA filters are used. Rooms with reversible airflow provisions for the purpose of switching between protective environment and All functions are not acceptable.
12. Food preparation centers shall have ventilation systems whose air supply mechanisms are interfaced appropriately with exhaust hood controls or relief vents so that exfiltration or infiltration to or from exit corridors does not compromise the exit corridor restrictions of NFPA 90A, the pressure requirements of NFPA 96, or the maximum defined in the table. The number of air changes may be reduced or varied to any extent required for odor control when the space is not in use.

TABLE 5
Final Occupancy Inspection Check List

Inspector: _____ Date: _____

Facility: _____ Job: _____

General Contractor: _____

The following items shall be located at the site and copies furnished to the Division of Health Facilities Services (DHFS) prior to the final inspection and approval for occupancy of the project area(s). These items are in no specific order. Some items may not apply in every case.

Item	Yes	No	Comments
1. <u>Architect/Engineer's Certification of Substantial Completion?</u>			
2. <u>Interior finishes - smoke development and fire spread rating information?</u>			
3. <u>Fire Protection Systems- Portable fire extinguishers are inspected, and tagged, and shop drawings for standpipe/sprinkler systems are available?</u>			
4. <u>Certificate of Occupancy - City Building Inspector?</u>			
5. <u>Certification - fire alarm system, smoke detection system, sprinkler system, and any other fire suppression system has been installed, tested and meets all applicable standards?</u>			
6. <u>Certification - medical gas system?</u>			
7. <u>Certification - electrical system has been installed, tested and meets all applicable standards of the NEC, NFPA?</u>			
8. <u>Certification - emergency generator has been installed, tested and meets all applicable standards of the NFPA, NEC?</u>			
9. <u>Certification - mechanical system has been installed, tested, balanced, and approved by the engineer of record?</u>			
10. <u>Certification - communication system(s) has been installed, tested and meets all applicable standards of the NEC, NFPA?</u>			
11. <u>Are there manufacturer's operation and maintenance manuals with equipment warranties on site for all newly installed equipment or a letter from the general contractor stating that the above items will be turned over to the owner?</u>			
12. <u>Have all applicable pieces of equipment installed during the construction been incorporated into the existing preventive maintenance system? Or, have new maintenance policies and procedures been written to insure that said items are maintained per the manufacturers recommendations?</u>			
13. <u>Are there as-built drawings on site or a letter from the general contractor stating that the as-built drawings will be turned over to the owner?</u>			
14. <u>Are there copies of the Architect's and Engineer's final punch lists with verification that all items have been repaired or remedied?</u>			

Referenced Publications.

1. General: These regulations include references to other codes and standards. The most current codes and standards adopted at the time of this publication are used. Later issues will normally be acceptable where requirements for function and safety are not reduced; however, editions of different dates may have portions renumbered or re-titled. Care shall be taken to ensure that appropriate sections are used.
2. Publications adopted in whole by these regulations are as listed below:
 - a. American National Standards Institute (ANSI) Standard A17.1, "American National Standard Safety Code for Elevators, Dumbwaiters, Escalators and Moving Stairs."
 - b. American Society of Civil Engineers, (ASCE), "Minimum Design Loads for Buildings and Other Structures."
 - c. National Fire Codes - 2002.
 - d. Rules and Regulations Pertaining to the Management of Regulated Waste from Health Care Related Facilities, Arkansas Department of Health.
3. Publications adopted in part (only the sections specifically identified by these regulations are applicable) by these regulations are as listed below:
 - a. American Society of Heating, Refrigerating and Air Conditioning Engineers (ASHRAE), "Handbook of Fundamentals" and "Handbook of Applications."
 - b. American Society of Heating, Refrigerating and Air Conditioning Engineers (ASHRAE), Standard 52, "Method of Testing Air Cleaning Devices Used in General Ventilation for Removing Particulate Matter."
 - c. Illuminating Engineering Society of North America, IESNA Publication CP29, "Lighting for Health Care Facilities."
4. A partial list of other publications that are applicable to the design and construction of healthcare facilities that are not a part of these regulations but may be enforced by other authorities having jurisdiction is provided below:
 - a. Arkansas State Fire Prevention Code Volumes I, II, and III (based on the 2000 International Building Code).
 - b. Arkansas State Mechanical Code, Arkansas Department of Health.
 - c. Arkansas State Plumbing Code, Arkansas Department of Health.

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- d. Arkansas Boiler Code, Arkansas Department of Labor.
- 5. Publications that are not a part of these regulations but potentially helpful as reference material in the design and construction of healthcare facilities are as listed below:
 - a. American Institute of Architects (AIA), "Guidelines for Design and Construction of Hospital and Health Care Facilities 2001 Edition".
 - b. American Society of Heating, Refrigeration, and Air Conditioning Engineers (ASHRAE), "HVAC Design Manual for Hospitals and Clinics".

Availability of Codes and Standards. Referenced publications can be ordered, if they are Government publications, from the Superintendent of Documents, U.S. Government Printing Office (GPO), Washington, DC 20402. Copies of non-government publications can be obtained at the addresses listed below.

- 1. Air Conditioning and Refrigeration Institute, 1501 Wilson Boulevard, Arlington, VA 22209.
- 2. American National Standards Institute, 1430 Broadway, New York, NY 10018.
- 3. American Society of Civil Engineers, 345 East 47th Street, New York, NY 10017
- 4. American Society for Testing and Materials, 1916 Race Street, Philadelphia, PA 19103.
- 5. American Society of Heating, Refrigerating, and Air Conditioning, 1741 Tullie Circle, NE, Atlanta GA 30329.
- 6. Arkansas Building Authority, 1515 West 7th Street, Suite 700, Little Rock, AR 72201.
- 7. Arkansas Department of Labor, 10421 West Markham, Little Rock, AR 72205.
- 8. Illuminating Engineering Society of North America (IESNA), 120 Wall Street, 17th Floor, New York, NY 10005.
- 9. National Fire Protection Association, 1 Batterymarch Park, Post Office Box 9101, Quincy, MA 02269-9101.
- 10. International Building Code Congress International, Inc., 900 Montclair Road, Birmingham, AL 35213.

Interpretations of Requirements.

- 1. Memorandum of Understanding: Conflicts between the Arkansas Fire Prevention Code and NFPA 101 Life Safety Code are to be resolved using the Memorandum of Understanding as indicated below:

- a. The Arkansas Fire Prevention Code is the fire prevention code for the State of Arkansas.
 - b. When the Arkansas State Fire Prevention Code conflicts with the chapters of NFPA 101 Life Safety Code governing new and existing health care and ambulatory health care occupancies (Chapters 18, 19, 20, and 21), the provisions of the Life Safety Code shall govern.
 - c. Requirements found only in the Arkansas Fire Prevention Code (requirements not addressed by NFPA 101) may be provided at the option of the facility (compliance with these requirements is not mandatory).
2. Safety Improvement Plans: Nothing in these regulations shall be construed as restrictive to a facility that chooses to do work as a part of a long-range safety improvement plan.
 3. Provisions in Excess of Regulatory Requirements: Nothing in these regulations shall be construed to prohibit a better type of building construction, an additional means of egress, or an otherwise safer condition than that specified by the minimum requirements of these regulations.
 4. Equivalency:

The Division may approve alternate methods, procedures, design criteria, and functional variations from these regulations, because of extraordinary circumstances, new programs, new technology, or unusual conditions when the facility can effectively demonstrate that the intent of the regulations is met and that the variation does not reduce the safety or operational effectiveness of the facility below that required by the exact language of the regulations.

FINANCIAL IMPACT STATEMENT

DEPARTMENT	Department of Health
DIVISION	Health Facilities Services
PERSON COMPLETING THIS STATEMENT	Renee Mallory
PHONE NUMBER	661-2201
FAX #	661-2165

SHORT TITLE OF THIS RULE **Rules and Regulations for Hospice in Arkansas**

1. Does this proposed, amended, or repealed Rule or Regulation have a financial impact? **No additional financial impact.**
2. Please estimate the cost of compliance to regulated entities & others outside the department. **None.** Identify any financial impact on municipalities or counties. **None.**
3. If you believe that the development of a financial impact statement is so speculative as to be cost prohibitive, please explain.
4. If the purpose of this Rule or Regulation is to implement a federal Rule or Regulation, please give the incremental cost for implementing the Regulation. **None.**

<u>2004-2005 Fiscal Year</u>		<u>2005 – 2006 Fiscal Year</u>	
General Revenue	_____	General Revenue	_____
Federal Funds	_____	Federal Funds	_____
Cash Funds	_____	Cash Funds	_____
Special Revenue	_____	Special Revenue	_____
Other	_____	Other	_____
Total	_____	Total	_____

5. What is the total estimated cost by fiscal year to any entity or individual subject to the proposed, amended, or repealed Rule or Regulation? **None.**

<u>2004 - 2005 Fiscal Year</u>	<u>2005 - 2006 Fiscal Year</u>
--------------------------------	--------------------------------

6. What is the total estimated cost by fiscal year to the agency to implement this Regulation? **None.**

<u>2004 – 2005 Fiscal Year</u>	<u>2005 - 2006 Fiscal Year</u>
--------------------------------	--------------------------------

7. Does the Proposed Rule impose a cost on state or local school districts? **No.** If yes, then file a fiscal impact statement.

References: Act 884 of 1995, Ark. Code Ann. § 10-3-309
 Act 1104 of 1995, Ark. Code Ann. § 25-15-204
 Act 221 of 1977, Ark. Code Ann. § 19-1-302